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A STUDY TO EVALUATE THE ORGANIZATION AND THE OPERATING PROCEDURES OF THE PATIENT ASSISTANCE FUNCTION AT BROOKE army MEDICAL CENTER, FORT SAM HOUSTON, TEXAS

A Problem Solving Project

Submitted to the Faculty of

Baylor University

In Partial Fulfillment of the

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of

Master of Health Administration

By

Major Irene Begg, AMSC

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At Brooke Army Medical Center, the Patient Assistance Offices, Public Affairs Office, Health Consumer Committee, and Inspector General's Office are the entities specifically organized for maintaining good consumer relations with patients. The adequacy of care, overall patient satisfaction, and the provision of avenues of access and redress for assistance and complaints are matters of concern. This study evaluates the organization and operating procedures of Brooke's Patient Assistance Offices. It sets forth valid recommendations for the improvement of the facility's consumer relations mission.

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CHAPTER I

INTRODUCTION

General Information

Brooke Army Medical Center (BAMC) serves a large and diverse patient population; although all personnel at BAMC are involved in consumer relations in some manner, those entities specifically organized to provide a system for maintaining good consumer relations are the Patient Assistance Offices, the Public Affairs Office, the Health Consumer Committee, and the Inspector General's Office. All are designed to allow for interaction between patients and consumer representatives and BAMC personnel on matters such as adequacy of care, overall satisfaction, and appropriate avenues of access and redress for assistance and complaints.[1]

The Ambulatory Patient Care (APC) models endorsed by the United States Army Health Services Command (HSC) provide guidelines for the organization and conduct of Patient Assistance functions in an Army medical treatment facility (MTF). At BAMC, evidence (supported by comments by Patient Assistance and Headquarters personnel) suggested that the implementation of these guidelines and the overall functioning of the Patient Assistance Offices could be improved. Specifically, it appeared that the data gathered from patients (such as requests for assistance and complaints) were not being adequately documented nor reported to those individuals with the authority and/or ability to take corrective action to prevent further complaints or to make necessary adjustments within the BAMC health care delivery system.

Conditions Prompting the Study

The following factors combined to spur an interest in an evaluation of the Patient Assistance functions at BAMC: (1) the lack of coordination in handling complaints and requests for assistance, (2) the need for revision of the inpatient and outpatient satisfaction survey questionnaires, (3) the need for an improved procedure for recording and analyzing patient complaints to insure data collected and trends observed were properly transmitted to individuals in authority, (4) the signs of job frustration on the part of the individuals tasked with the bulk of the Patient Assistance work at BAMC, (5) the increase in the scope of services provided at BAMC and the resulting increase in workload, (6) the planned nine million dollar facilities upgrade project for the physical plant which would cause inconveniences and problems for patients and care providers, (7) the current emphasis on accountability to patients and taxpayers for the provision of health care in both military and civilian health care delivery systems, and (8) the perception at BAMC that the Patient Assistance Offices were "complaint departments."

Statement of the Problem

The problem was to evaluate the organization and operating procedures of the Patient Assistance functions at BAMC and to make recommendations for improvement in the system.

Objectives

The following were the objectives to be accomplished during the study:

--Analyze the organization and staffing of the existing Patient Assistance Offices at BAMC

--Analyze the existing data collection and information dissemination

procedures used by Patient Assistance personnel

--Discuss and compare alternative methods of organization and staffing of the Patient Assistance Offices

--Devise and discuss alternative procedures for data collection and information dissemination used by Patient Assistance personnel

--Recommend possible actions for improving the organization and procedures of the Patient Assistance Offices.

Assumptions

Two general assumptions were made regarding consumer relations and health care facilities. First, the consumer's role in health care would continue to receive emphasis and attention in both literature and legislation with consumerism becoming a stronger force thus increasing the need for health care facilities to provide information to patients and receive feedback from patients regarding the care offered. Second, the demands for accountability of health care providers in military facilities to patients, taxpayers, and lawmakers for the quality of care provided and the expenditure of tax dollars for such care would increase with the growing concern for rising taxes and their use.

Several assumptions were made specific to BAMC. First, during the past three years the workload handled by the Patient Assistance Offices has increased steadily[2,3] and this trend would continue. Two additional assumptions support the previous one. As BAMC continues to grow (in size of services within the facility, in educational programs for health care providers, in numbers of patients) in the midst of tighter budgets, the need for information exchange between patients and BAMC personnel regarding changes in policy, procedures, services offered, etc. would increase; also, over the next two

and one-half years (at least), the facilities upgrade project would increase the number of questions, requests for assistance, and complaints received from patients.

It was assumed that there was a sincere interest in consumer relations, Patient Assistance functions, patients' opinions, patient education, and feedback to health care providers on the part of the Commanding General (CG), Chief of Professional Services (CPS), and Executive Officer (XO) at BAMC.

Finally, an assumption was made regarding semantics. In 1977 HSC initiated the use of the title "Patient Representative"[4] in preference to "Patient Assistance" and in the literature the word "representative" is used mostly frequently to indicate patient advocate or patient assistance personnel and functions. At BAMC "Patient Assistance" has been used since the inception of the program and the title has never been changed. It was assumed that the use of the term "representative" generically throughout the study and the use of the term "assistance" when referring to specific individuals, offices, or functions as BAMC would not be overly confusing to the reader.

Factors Affecting the Study

Numerous factors have a bearing on the study; a few were limiting to a significant degree. First was the evolution of the role of the Patient Assistance Officer at BAMC from a full-time Medical Service Corps (MSC) officer, to the "double-hatting" of the Assistant Executive Officers at the Main Hospital and Beach Pavilion with Patient Assistance functions, to the assumption of most of the Patient Assistance work at Beach Pavilion by the clerk-typist in the Office of the Assistant Executive Officer-Beach Pavilion; this created management and coordination problems in the handling of Patient

Assistance functions and engendered confusion which resulted from a lack of solid facts describing the evolution of the jobs. Individuals who held the initial jobs did not keep appropriate records (or if these were kept they were lost or destroyed); the individuals initially assigned were apparently not adequately prepared for the jobs and may not have been enthusiastic about Patient Assistance work. The current incumbents in the jobs perceive that they were assigned the tasks with little explanation or preparation by their predecessors.[5,6] Consequently, background information for the study was less than adequate.

Another factor affecting the study was the fragmentation and proliferation of patient advocate activities throughout BAMC that could not be adequately controlled or coordinated by any Patient Assistance system. A patient could tap various resources for assistance with problems; in addition to the two Patient Assistance Offices there are the Inspector General (IG), Adjutant, American Red Cross (ARC), Social Work Service (SWS), Community Health Nurses, Army Community Services, and direct access to the CG, CPS, and XO.

Changes in philosophy and attitudes by individuals in key roles in BAMC were also a factor. At the beginning of the study, BAMC's CG had been in command for less than six months; the CPS was new to his position; and the Assistant Executive Officer-Beach Pavilion (BP) and the Administrative Officer in the CPS Office were relatively new to their positions. The XO retired from the service prior to the conclusion of the study. These personnel actions affected attitudes and actions throughout BAMC and had an effect on the Patient Assistance functions throughout the study.

The dynamics of the situation at BAMC during the seven months in which the data for the study were collected were a factor that led to improvements

and change within the Patient Assistance system during the study. Because these changes involved implementation of some of the actions recommended by the writer, it was considered appropriate to include all recommendations that resulted from the study indicating those which had been implemented either partially or fully.

The Management By Objectives (MBO) effort at BAMC was both an example of the dynamics and a factor affecting the study. Broad MBO goals were developed for the first quarter of Fiscal Year 1979, refined into performance goals, and adjusted during the second quarter. Several goals were integral to the study's objectives and in turn were affected by the study; the action officers provided input into the study and the recommendations of the study have a direct impact on goals as stated and measured. Those goals were the following: (1) develop a system for monitoring Patient Assistance action, (2) develop a monthly reporting system for providing information on justified complaints to include Patient Assistance data, trends, etc. to departments and separate services, (3) develop criteria for classifying complaints as justified/unjustified, (4) revise the form for reporting Patient Assistance visits, and (5) survey a statistically adequate sample of BAMC outpatients and inpatients. Consistent with the last goal, emphasis was placed on obtaining the maximum percentage of outpatients expressing satisfaction on the annual outpatient survey and a maximum of inpatients expressing satisfaction on the semi-annual inpatient surveys; this was intended to focus on the key result area of quality of care.[7] It impacted on the planned revision of survey forms and proposed methods for conducting inpatient and outpatient surveys.

The size and physical layout of the BAMC facility were factors in

attempts to observe the functions of the Patient Assistance Offices and in devising organization schemes for these functions. The facility is dispersed among numerous buildings and space is an increasingly scarce resource.

The willingness of individuals to communicate freely with the writer was also a factor. While most individuals were candid, others attempted to answer questions with what they believed should be rather than what existed (if what existed would reflect badly on BAMC). While admirable in intent, this tended to strain credibility in the face of reliable evidence to the contrary.

A limiting factor to the study was the state of the Public Affairs Office at BAMC during the major portion of the seven month period. Technically, patient relations are part of the command information portion of the Public Affairs function.[8] Coordination and cooperation between the Public Affairs personnel and the Patient Assistance personnel are essential as the Public Affairs Office provides the means of reaching large numbers of consumers through the news media. Originally the study was designed to encompass an analysis of the Public Affairs function and its interrelationship with the Patient Assistance function. However, the Public Affairs Office was undergoing major changes during the study and it was determined that the analysis of that function should be deleted from the study and addressed elsewhere.

The HSC involvement with and regulatory requirements for APC functions were also factors. An annual outpatient satisfaction survey using the HSC specified form is a requirement at each MTF; this form was one identified as being in need of revision and thus any decision at BAMC to adopt a modified form would require interaction with HSC for approval. Additionally, the philosophy of HSC in regard to the APC Program has undergone a major shift. While the initial APC models focused on outpatient services within medical

centers and medical department activities (MEDDACs), emphasis at HSC has shifted to troop medical clinic activities and the use of physician extenders; while this is appropriate to the medical mission, the lack of interest or apparent concern by the HSC APC Division for those performing Patient Assistance functions in HSC facilities had an effect on those programs.[9]

The interest of the HSC IG Team in the Patient Assistance functions at BAMC and their comments on that area were a factor as the Problem Solving Project Proposal for this study was used in an attempt to indicate to the Team that what the Team had perceived as problems with the BAMC Patient Assistance functions had been identified and were being addressed. The Team did not agree that the existence of the study was sufficient to negate the need for IG recommendation for actions to be taken; consequently, some actions (which were part of the dynamics mentioned earlier) were taken to accommodate the Team's findings and recommendations.

Review of the Literature

The health care industry and particularly hospitals have been the focus of increasing scrutiny over the past years. While the steadily increasing cost of hospital care has received the most attention by the media, lawmakers, and consumers, accountability to patients for quality of care has also been a vital issue. Consumer rights movements have encompassed the patient's right to at least adequate care and to information about that care. It is apparent that health care providers need to foster and maintain rapport between themselves and their consumers and in some cases to regain the confidence of their patients. Articles relating to the trauma patients feel in the hospital abound--often written by practicing physicians who have taken an humanistic look at the "caring" for patients.[10,11]

Numerous studies have established that patients are unhappy with health care provided as they relate their experiences in the health care setting as having been confusing, frustrating, and humiliating. Frequently cited as causes for such unhappiness are staff rudeness, lack of concern, misinformation or lack of information about policies and procedures, and depersonalization.[12, 13]

Many patients voice the complaint that "nobody tells me anything" or that what is said is not expressed in language that the layperson can understand. A common observation in outpatient areas is that patients feel they are treated as numbers or disease classifications and not as individuals with feelings and failings.[14]

Some patients are unable to communicate complaints or are reluctant to do so for fear of retaliation by those individuals providing care through the withholding of services or delay of services. Patients are intimidated by physicians, nurses, and the complexities of medical technology that surrounds them. They may be embarrassed to question a physician or other health care provider at length for fear of appearing ignorant.[15]

When an individual is hospitalized, the primary illness is frequently compounded by anxiety, reaction to separation from familiar surroundings and family, fear of the unknown, and the inability to understand what is happening. In addition, one's cultural and ethnic background and beliefs affect one's attitude toward one's illness and treatment.[16]

Recognizing that it is important that health care providers show patients that they "care to give care while caring," the American Hospital Association (AHA), the Joint Commission for the Accreditation of Hospitals (JCAH), and other national health organizations have emphasized the need to address the

psychosocial needs of the patient. Statements address not only the development of mechanisms for investigation of complaints of patients and their families but also mechanisms for providing assistance and support to patients and their families as they attempt to cope with the emotional problems that hospitalization or outpatient treatment can cause. Additionally, emphasis has been placed on developing mechanisms necessary to make staff members aware of their roles in maintaining an atmosphere that favorably affects a patient. Although patients may perceive care as inadequate, more problems stem from human relations aspects and the need to humanize and personalize the dehumanizing patient care experiences--perhaps a consequence of the concern for cost control and efficiency or a lack of a true "caring" spirit by health care personnel.[17,18]

Human relations programs are a valuable tool in educating hospital staff to the needs of patients but equally valuable is the role of the patient representative who provides the link between the patient and the institution. The patient representative is the one to whom patients are more likely to be free in expressing concerns and complaints and asking questions. By listening to patients' questions, requests, and complaints, the patient representative can not only solve problems for the patient but provide vital feedback to the staff upon which can be based training or awareness programs for personnel as well as actions to remedy problem-causing areas within the facility.[19]

The main goals of the patient representative are to establish liaison between the patients and the health care facility and to humanize the health care environment for the patient and family. Ideally all members of the health care team should be patient representatives and all should by their attitudes and actions negate the requirement for a complaint and assistance department; realistically, this is not possible. Therefore, the patient representative, whose sole job is to assist the patient in need and act as

an advocate for the patient, is the best means of assuring that the patient is given the attention and "caring" required.[20]

Patient representatives have been in existence in American Hospitals since the late 1960's and the phenomena has grown so that currently the number of American hospitals with formalized patient representative programs exceeds 1500.[21] Patient representatives in civilian hospitals are oriented toward inpatient services, although some work is done in emergency rooms and large outpatient departments. In military hospitals, patient representatives are mainly oriented to outpatients (as this is the largest workload) with less emphasis on the inpatients and their problems.

The Society of Patient Representatives of the American Hospital Association was founded in 1972 with 100 members. The goals of the society include the following: (1) providing a method for career definition and the exchange of procedures and ideas among society members, (2) acting as an information source about current trends in patient representative programs, (3) providing educational programs for patient representatives throughout the nations, and (4) increasing and maintaining awareness of patient representative programs in all types of health care institutions.[22]

To be eligible for membership an individual must have patient representative functions as the primary assignment and must be employed by an institution affiliated with the AHA or be an employee of a community or governmental health/welfare agency performing the functions of a patient representative. While membership requirements prevent some individuals who perform patient representative functions from joining the society, at the current time the society has grown to over 700 members and at regional levels has been reported to be providing needed support to members who are attempting to define their

roles and refine their methods of communication and problem-solving.[23, 24]

Most patient representatives attempt to enforce a patient's bill of rights patterned after that approved by the AHA (see Appendix A) and most also attempt to adhere to the rights and responsibilities guidelines set down by the JCAH which has progressed from addressing patients' rights in the preamble to the 1974 Accreditation Manual to a separate section in the 1976 Manual to an annotated section in the 1979 Manual (see Appendix B). Although accreditation standards for patients' rights are not yet in existence, it is conceivable that the JCAH will have standards for assuring patients' rights in the future.

Various individual and legal opinions have suggested that the AHA's Patient Bill of Rights should be modified because it poses dire legal problems if violated; however, to meet the JCAH guidelines, many hospitals have adopted the AHA bill or have revised it to suit their own needs.[25, 26]

The amount of authority given to patient representatives varies. In some facilities patient representatives can adjust or write-off hospital bills or can change or circumvent hospital protocols in administrative situations in an attempt to cut "red tape" or rectify errors. In other facilities, patient representatives have less authority for action but do insure that the patient gets a sympathetic hearing, with the hospital staff and/or physician involved having input and the administrator or chief executive officer making the final decisions and taking action when needed. A few patient representatives feel powerless because they have no authority (some are not permitted to approach physicians about complaints), suggest that they are not truly advocates, and experience much frustration with their work.[27,28]

Educational background varies among patient representatives depending on the roles and duties assigned. Some are little more than personal aides who purchase comfort items for patients, write letters, etc. and may be volunteer workers with high shcool educations or less. Others are college graduates who are salaried employees whose daily activities may include serving as an advocate in questioning a patient's hospital bill with the business office or a patient's proposed treatment plan with a health care provider. Some university hospitals have a large staff of patient representatives (twenty or more) which includes both type of individual hierarchically organized to allow for both types of functions noted above.[29,30]

The literature indicates that the majority of patient representatives are female. Whether this is a result of sexual stereotyping, salary, or innate ability to deal with complaints and frustration while maintaining a sympathetic attitude cannot be determined by this study and has not been specifically addressed in the literature.[31,32]

Proponents of the patient representatives state that these individuals are the most outstanding vehicles for communication between the patient and the institution. Opinions of the effectiveness of patient representatives differ, but the positive opinions are more numerous. While some critics indicate that the patient representatives are only public relations personnel who are meant to calm patients and keep complaints down without affecting change or taking action, others state that the patient representatives are antagonistic toward the hospital and view their role as trying to prove that someone (usually a physician) is not doing the job properly. The middle to positive viewpoint indicates that patient representatives attempt to be objective and solve problems rather than taking sides (although many tend to lean toward the patients in loyalty) and in doing so improve the quality of service

by humanizing the hospital, pinpointing problem areas, and in some cases preventing potentially costly malpractice suits.[33, 34]

Patient representatives are also viewed as an attempt to delay or stop a national trend toward the creation of an independent corps of patient advocates (probably government sponsored). At the present time several states (including Texas) have toll-free "hot-lines" for nursing home patients to use to report complaints about care to a state office which investigates such complaints. Some state and federal agencies require health care facilities to have a mechanism for handling patient complaints. A patient complaint procedure must exist in a hospital before reimbursement for certain treatment (such as that for end-stage renal disease) will be provided by Medicare; statements on patients' rights and a patient representative program are required for participation in Medicare by skilled nursing homes.[35] While these requirements can be met in a minimal manner, they set precedents in a time of increasing government and consumer interest in health care.

Concepts most frequently stated in the literature as essential to insure an effective patient representative program include the following:

--Patients should be made aware of the mechanism by which they can communicate their concerns and complaints to the patient representative and of how that mechanism works

--A specific individual(s) should be assigned as the liaison between the patient and the institution

--Everyone working for the institution who comes in contact with patients should know who the patient representative personnel are and how to relay information to those individuals

--Appropriate monitoring should be established to identify services,

departments, activities, policies, etc. where action is required to correct problems and follow-up action should be mandatory

--Means of providing feedback from patients regarding their perceptions of the institution and the care they received (satisfaction surveys, interviews, etc.) should be utilized regularly to supplement the information gathered by the patient representatives through direct contact with patients

--Patient representatives should be able to cross departmental lines and to interact with hospital personnel on any level within the organization

--Patient representatives should have direct access to the administrator or chief executive officer to allow for that individual's support and action in those instances when such action is needed to solve problems

--Orientation and in-service training programs should exist for all hospital personnel to heighten awareness of the patient's perception of the hospital and the patient representative should have input into such programs based on past experiences with patients

--Patient representative programs should not be limited to reaction to crises and problems but should be geared to action that increases information flow between the patients and the institution

--The scope of the duties of the patient representative should be clearly defined in a job description which states both responsibilities and authority

--Copies of all informational material provided to patients and of all relevant institution-wide policies and procedures of which the patient representative must be aware should be on file in the patient representative's office and available for ready reference when needed to assist in answering patients' questions.

Research Methodology

The research methodology followed in the study was that designated as "action research" in the Handbook of Research and Evaluation by Stephen Isaac and William B. Mitchell; the purpose of action research is to develop new skills and to solve problems with direct application to the working world setting. Action research is flexible and adaptive and favors responsiveness and innovation rather than control. Because action research is situational and has little control over independent variables, it lacks "scientific rigor" but in its attempts to be systematic is useful in a practical sense.[36]

The approach to action research in the study involved two steps. First was a review of the literature and second the acquisition of empirical data. The primary source of this empirical data was interview and observation of personnel in the Patient Assistance Offices at BAMC. Additional data was acquired through interviews with other personnel and patients at BAMC and through interviews and correspondence with individuals working in patient relations programs and consumer relations programs and administrative personnel at selected civilian and military health care institutions.

Although Patient Assistance is part of a greater program--the Consumer Health Program[37]--and working with the Patient Assistance personnel and others at BAMC uncovered problems in other areas that were integral to good consumer relations (Public Affairs Office, Human Relations Training Program, patient education, etc.), this study was limited by design to the evaluation of the Patient Assistance functions. However, in those associated areas where the Patient Assistance personnel themselves or data collected and information disseminated by those individuals had a direct impact, recommendations for

changes were considered and included.

The annual outpatient satisfaction survey was completed in November 1978 using the HSC authorized form while an inpatient survey was conducted in March 1979 using the current BAMC form. Therefore, the survey forms devised as part of the study were not tested. These forms were constructed as composites of input from many individuals, the literature, and selected forms used by other facilities; the forms are the product of decisions and judgment of the writer and reflect that individual's opinions. The forms devised for recording and reporting assistance and complaint actions were being tested informally by the Patient Assistance personnel at the termination of the study.

Criteria

There were two broad categories of criteria by which the proposed alternatives were evaluated; these were in keeping with the HSC, AHA, and JCAH guidelines and concepts extracted from the literature. The first dealt with the organization of the Patient Assistance functions; specific criteria were the following:

--The organization should insure an integrated approach to Patient Assistance with a minimum of duplication of effort and no gaps in coverage or breakdown in communication of information from input by patients to feedback to patients and/or appropriate staff

--The responsibilities, duties, and authority of the Patient Assistance personnel and the chain through which complaints are routed and through which the Patient Assistance personnel are supervised should be clearly defined

--An adequate number of properly trained personnel should be

assigned to the Patient Assistance Offices.

The second broad criterion dealt with the procedures for data collection and information dissemination and emphasized relevancy, reliability, and validity of data and information; specific criteria were the following:

--Standard procedures should be used in both Patient Assistance Offices for recording and reporting requests for assistance and complaints

--Those procedures should insure that revelant information reaches appropriate staff members in a useable format and within a reasonable period of time for any necessary corrective action to be taken

--Forms required for recording initial individual complaints should be comprehensive in amount and type of data recorded and should include the Privacy Act statement as an integral part of the form

--Forms required for recording requests for assistance and complaints in summary form should be comprehensive in amount and type of data recorded, should be multi-purpose and flexible enough to allow for use daily/weekly/monthly in reporting to various individuals who have a need for such information (CG, CPS, XO, IG, etc.), and should be time-saving for the Patient Assistance personnel (but not at the expense of collection of needed data)

--Procedures for conducting satisfaction surveys should assure revelancy, validity, and numerical adequacy of population surveys

--Procedures for compilation, tabulation, and dissemination of survey results should assure that meaningful comments as well as statistical analysis are available for review and action by appropriate staff members

--Forms designed for satisfaction surveys should include questions to cover: (1) those items identified by BAMC Patient Assistance personnel as appropriate and specific to BAMC, (2) the AHA and JCAH guidelines as to

patients' rights, and (3) the BAMC MBO goals as appropriate to quality of care.

--Forms designed should fulfill criteria indicated in the literature as appropriate for questionnaire design to include: (1) use of language that is familiar and appropriate for the target population, (2) formulation of questions to assure respondent recognizes whether a factual answer or an opinion is solicited, (3) design of form that is neat, legible, and well-organized, (4) allowance of adequate blank space for responses and for free-form comments, (5) inclusion of no items without a deliberate commitment to analyze the responses, (6) allowance of adequate blank space so as not to overcrowd the form with words or lines, (7) brief but clear explanation of use of the questionnaire, (8) grouping of questions with similar type responses, and (9) design of answer options to be mutually exclusive and sufficient to cover each conceivable answer[38, 39]

--Necessary policies, procedures, and patient education reference materials should be maintained by Patient Assistance personnel and should be readily available for use by such personnel in assisting patients

--All BAMC personnel should be aware of the existence of the Patient Assistance program and of the identity and location of the Patient Assistance Offices.

Footnotes

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[8]U.S., Department of the Army, Public Affairs Support Model, Health Services Command APC Model #15 (Fort Sam Houston, Texas, 1977), p. 2.

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[15]Alexandra Gekas, "Good Patient Relations Can Help Abate Potential Risk Situations," Hospitals 51 (16 May 1977): 58.

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[22]The Society of Patient Representatives of the American Hospital Association (pamphlet).

[23]Novack, p. 26.

[24]Telephone Interview with Jack M. Tiller, Patient Assistance Officer/ Public Affairs Officer, U.S. Army Medical Department Activity, Fort Jackson, South Carolina, 15 December 1978.

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[27]Novack, P. 26.

[28]Evelyn McNamara M. and Arline B. Jax, "Hospital Social Workers and Patient Representatives," Hospitals 48 (1 May 1974): 14.

[29]Correspondence from Donna Albee, Health Care Administrative Resident, Dwight David Eisenhower Army Medical Center, Fort Gordon, Georgia, 8 March 1979.

[30]Novack, p. 26.

[31]Tiller, 15 December 1978.

[32]Interview with Robert E. Wright, Patient Assistance Officer and Assistant Executive Officer - Beach Pavilion, Brooke Army Medical Center, Fort Sam Houston, Texas, 15 March 1979.

[33]Ruth Ravich, "Patient Relations," Hospitals 48 (1 April 1974): 107.

[34]Novack, p. 26.

[35]Gekas, pp. 58-60.

[36]Stephen Isaac and William B. Michael, Handbook in Research and Evaluation, (San Diego: Robert R. Knapp, 1974), pp. 40-44.

[37]Army Regulation 40-2, p. 14-1.

[38]Douglas Berdie and John F. Anderson, Questionnaires: Design and Use, (Methuchen, N.J.: Scarecrow Press, 1974), pp. 11-62.

[39]Michael McKillip, "How to Get Reliable Information From Surveys," Cross-Reference, May-June 1977, pp. 8-9.

CHAPTER II

DISCUSSION

Patient Representative Activities at Organizations Outside BAMC

In the early 1970's the United States Army Surgeon General began placing increased emphasis on the quality of care given to outpatients within Army Medical Department (AMEDD) facilities. This was the impetus for the HSC APC Program of which the Patient Representative function is a part. The number of Patient Representative personnel in a given facility was to be based on the number of outpatient visits to that facility in one day (as there was no manpower yardstick); the numbers used as guidelines for numbers of personnel, the duties of such personnel, and the criteria for selection of personnel were outlined in APC Model #23--Patient Representative Officer (see Appendix C). An outpatient satisfaction survey was to be conducted annually in accordance with guidance and sample forms provided in APC Model #15--Public Affairs Support Model.[1] From the onset, the emphasis for Patient Representative work was with the outpatient.

The current APC Program Director at HSC and his staff members were not able to identify the individuals performing as Patient Representative Officers (PROs) within HSC facilities; no list of names existed and there was no record of rank or grade of individuals performing those functions. There appeared to be little or no interaction between the HSC APC personnel and PROs. When APC Model #23 was written in 1974 it contained the requirement for a monthly report to HSC from the PRO but the report was discontinued prior

to 1977 as it was not felt to be useful to HSC personnel.[2] Although the current APC Program Document states that a PRO will be assigned at each facility and this requirement is part of the checklist used by the HSC IG Team on annual inspection visits, the APC Program Director was not aware that this requirement was stated in the document--he is proponent for the document--nor was he aware of the existence of the Society for Patient Representatives and that several HSC civilian employees were active members of that organization.[3]

The annual HSC outpatient satisfaction survey was initiated with the APC Program; the current survey form is a revision of the original form and was first used in 1975. It is a standard form designed to be applicable to all HSC facilities and to be computer processed. Results are presented as percentages of satisfaction with specific outpatient areas as expressed by patients. The survey has been conducted at HSC facilities during one week in November of each year. The results of the survey are intended to be for the benefit of the local facility; HSC involvement with the annual survey has been with the computer processing of the key-punched results and with assuring that facilities comply with the annual requirement.[4]

During the first computerized survey in 1975, response from the HSC facilities was one hundred percent. Since that time less than fifty percent of the facilities have conducted the survey each year and last November less than forty-three percent conducted the survey.[5] Although the survey is a requirement and an item of HSC IG interest, HSC has not actively enforced the requirement within the past three years. Neither the APC Program Director nor the APC Program Analyst could provide the writer with any records of which facilities had conducted surveys regularly.[6,7]

It was indicated that several individuals and facilities had presented comments and recommendations for changes in the survey form to HSC--although none of these comments or recommendations were on file--but that such changes could not be considered because to change the form would require changing the computer program and that was not possible.[8] Overall, the interest of the APC Program Director and staff in the on-going PRO activities appeared to be minimal; no active support or guidelines appeared to be forthcoming from that group.

Within HSC, several facilities have officially recognized requirements for PROs; among those facilities are William Beaumont Army Medical Center; the Medical Department Activities at Forts Benning, Carson, Hood, and Stewart; and BAMC. Many HSC facilities have additional duty PROs--usually a combination of Public Affairs Officer and PRO.[9,10] One-half of the personnel within HSC performing PRO duties are civilian.[11] In the opinion of the writer as based on information collected through interviews, the facilities with the most active Patient Representative Programs are the MEDDACs at Forts Belvoir, Benning, Carson, Hood, Jackson, and Ord. Outside HSC, the Patient Representative Program has received emphasis in AMEDD facilities in Germany; one of the Social Work Service Officers currently assigned to BAMC served as full-time PRO in an AMEDD facility in Germany and was extremely well supported by the command as well as very busy.[12]

The PROs or knowledgeable administrative personnel at a representative sample of HSC facilities were contacted and questioned about the use of the outpatient satisfaction survey. Most facilities that used the survey indicated it was better than nothing while those facilities that did not conduct a survey indicated it was not worth the effort. The two most common reasons given were

that the form was inadequate or inappropriate (items do not apply, important areas are omitted, etc.) making the percentages of satisfaction of little value or meaning and that the effectiveness and responsiveness of the Patient Representative Program at their facility allowed them to obtain a more accurate evaluation of patient satisfaction--both outpatient and inpatient.[13]

Among local health care facilities in the San Antonio area, the Bexar County Hospital District has a very active Patient Representative Program with PROs working at both the Robert B. Green Hospital (mostly outpatient clinics) and the Bexar County Hospital (mostly inpatient). These individuals are bilingual and spend a majority of the time in the clinics and on the wards helping patients handle a variety of problems; they function as advocates who interact with staff in both the administrative and medical professional areas. The administrator of the Bexar County Hospital District is pleased with the work done by the PROs. No patient satisfaction surveys are conducted within the Bexar County Hospital District facilities.[14]

At the Cancer Therapy and Research Center (outpatient services only), a patient advocate interacts with each patient and family; this individual functions from a psychosocial viewpoint in attempting to help cancer patients and their families deal with the ramifications of the cancer therapy. However, at times the need for typical Patient Representative problem-solving activity is required and this individual is the liaison between the patient and the Center. Each patient at the Center receives a patient questionnaire requesting evaluation of the Center and suggestions for changes. Each patient who resides outside the San Antonio metropolitan area receives a second questionnaire dealing with housing, transportation needs, and other problems that might influence that patient's perception of the care and treatment provided.

The administrator of the Center strongly supports the work of the patient advocate and is enthusiastic about the feedback received through the patient surveys.[15]

Audie Murphy Memorial Veterans Administration Hospital has an ombudsman assigned to the facility; however, this individual functions mainly as a liaison between the patient and the Veterans Administration and not between the patient and the hospital.[16] As Audie Murphy utilizes the primary nursing concept, the nurses are perceived as the patient advocates and some attempt to actively function in that role.[17,18] The ombudsman and an annual patient satisfaction survey are mandated by the Veterans Administration Department of Medicine and Surgery; however, at Audie Murphy a survey has not been conducted during the past two years.[19]

United States Air Force hospitals conduct inpatient and outpatient satisfaction surveys at least annually; each facility has a survey form specific to that facility. The patient advocate functions appear to be conducted as part of the registrar or medical administration function within the facilities.[20,21]

Analysis of the Current System at BAMC

The Patient Representative functions at BAMC do not strictly adhere to the APC models; the models suggest close coordination between the PRO and the Public Affairs Officer. Within the current APC Program Document in a chapter devoted to community relations, the section pertaining to the PRO contains special instructions which indicate that the Patient Representative functions are a part of the overall public relations effort and the Public Affairs Officer and the PRO should maintain close coordination.[22] At BAMC

there is little interaction between these individuals and the functions are definitely split. The BAMC Organization and Functions Manual describes the two functions as having little interaction.[23] The current Public Affairs Officer had no awareness of the APC Models when initially interviewed and no interest in the work done by the Patient Assistance personnel at BAMC.[24]

The Patient Assistance function began at BAMC with an MSC officer and an enlisted specialist assigned full-time to an office located in the Main Hospital. In 1976, the MSC officer informed the BAMC XO that there was not enough work to do and requested another position. The Patient Assistance functions were then split between the Assistant XOs at the Main Hospital and Beach Pavilion as additional duties and the other military personnel were reassigned.[25]

One problem for a military PRO is that forwarding or pursuing a patient complaint can reflect on the PRO and may affect that individual's career--particularly if the Patient Representative function is viewed as a complaint and/or patient placation department and forwarding a complaint means one is not doing an effective job.[26] That perception and its possible affect on career progression may have been one reason the MSC officer requested another job. Considering the workload performed by the current incumbents and learning that the officer did not like Patient Assistance work,[27,28] one may hypothesize that the officer may not have been truthful with the XO; if so, that was unfortunate as it may have given individuals in BAMC Headquarters the impression that Patient Assistance work did not require two full-time individuals--which had originally been recognized as the requirement.

Currently at BAMC there are two Patient Assistance Offices and two individuals designated as Patient Assistant Officers; these are located in the

Main Hospital and at Beach Pavilion. The office in the Main Hospital is located on the first floor near the Outpatient Pharmacy and the Obstetrics/Gynecology (OB/GYN) Clinic; the door to the office is always kept closed. The office is large and fairly pleasant by BAMC standards and connects with the office for the Engineer Liaison person for the Main Hospital. Privacy for the Patient Assistance Officer-Main Hospital (MH) and patients can be obtained when necessary by closing the connecting door. However, the Patient Assistance Officer-MH indicated that a more private office is needed because there are too many interruptions in the office and no waiting area for patients; when he is busy with a patient, other patients must stand waiting in the hallway.

The Patient Assistant Officer-MH is a senior non-commissioned officer (NCO) responsible for the wards, clinics, and services in the Main Hospital and the clinics in Reid Hall. As Assistant XO-MH, he is the building manager/supervisor for the Main Hospital, Reid Hall, and the Headquarters Building. This individual has no clerical support other than a student worker or a patient from the Medical Holding Company; such personnel, when available, may answer the telephone, greet visitors, and provide office coverage when the Patient Assistance Officer/Assistant XO-MH is out of the office. The Assistant XO-MH is responsible for liaison with the Engineer Liaison person and must receive and transmit all work order requests for those buildings under his supervision. Additionally, he handles the procurement, coordination, and assignment of all the student employees utilized in various departments throughout BAMC as semi-skilled help; at times the number exceeds ninety young people.

Approximately fifty percent of this individual's time is spent on

Patient Assistance functions and fifty percent on Assistant XO duties. He reports directly to the BAMC XO in both roles. He has been performing Patient Assistance duties for the past two and one-half years and during that time has attended one workshop--on customer awareness. He types his individual patient complaint reports and the weekly report to the CPS; he provides input to the Patient Assistance Representative-Beach Pavilion (BP) for a consolidated monthly report to the CG. He also maintains an informal log of all assistance rendered and complaints processed. He visits wards and clinics in the Main Hospital but his visits are mainly as Assistant XO-MH in a building manager/supervisor role and his interactions are with staff members for the most part.

The Patient Assistance Officer-MH appears to be protective of BAMC and indicated that he views his role as one of solving patient problems with the goal of preventing troubles for BAMC and keeping problems from reaching Headquarters levels. Being Assistant XO-MH, and thus having something to offer staff in return for favors in helping to solve patient problems, and knowing the military system as only an NCO can, have been extremely beneficial in his interactions within the Main Hospital as Patient Assistance Officer-MH; he indicated that his working relationships with most personnel were very good. He was not aware of the Society of Patient Representatives and was not interested in membership.[29]

He appears to be a dedicated and conscientious worker but shows signs of "burnout" as far as the performance of Patient Assistance duties. He indicated to other personnel that he is tired of that type of work[30,31] but he was reluctant to admit such to the writer; he did admit that although he would be willing to work full-time as Assistant XO-MH, he would not be willing

to work full-time as Patient Assistance Officer-MH. He is extremely busy and believes there is enough work for full-time individuals in each role.

He stated that the workload in the Patient Assistance area has increased over the past two years; and although he did not volunteer for the position and judged that he had been assigned with little preparation, he recognized the importance of having someone to whom patients can bring problems and complaints. He believes it prevents a waste of health care provider time in those cases where a patient needs to ventilate frustration and it gives the patient the chance for an impartial hearing at a level less than the IG.

His only complaints related to the amount of time he had to spend keeping records of formal complaints (although he realized the importance of such records) and the fact that the number of requests for assistance or complaints handled does not accurately reflect the amount of time spent on each patient--some actions take minutes, others hours, others days. Also, he speculated that others within BAMC probably were not aware of the amount of work being done in the Patient Assistance Offices.[32]

The Patient Assistance Office at Beach Pavilion is staffed with a lieutenant colonel MSC officer who is both the Patient Assistance Officer-BP and the Assistant XO-BP and with a civilian Patient Assistance Representative/Clerk. These individuals are responsible for the wards, clinics, and services in Beach Pavilion, Chambers Pavilion, the Dental Activity facilities, the Troop Clinic, and the Area Laboratory Service; the Patient Assistance workload at this office is almost twice that of the Main Hospital. The Assistant XO-BP is the building manager/supervisor for Beach Pavilion and has enlisted support in performing this task.

The office for the Patient Assistance personnel in Beach Pavilion is

located on the first floor near the Main Entrance and the Information Desk. The door to the office is always open and the area in which the Patient Assistance Representative-BP works is extremely small even by BAMC standards. There is no waiting area and patients must stand in the hallway when waiting to see Patient Assistance personnel. The Engineer Liaison person for Beach Pavilion is located in an office connected to the Patient Assistance Office (in keeping with the Assistant XO-BP's responsibility for all work order requests for the building); at the beginning of the study there was no privacy for the Patient Assistance Representative-BP as the entrance to the Engineer Liaison Office was through the office of the Patient Assistance Representative-BP and the parade of carpenters, ward personnel with work order requests, and sundry others hardly ever ceased. In early 1979, an entrance to the Engineer Liaison Office was provided and the Patient Assistance Representative-BP gained a small amount of privacy when working with patients; many times it is necessary for her to take distraught patients into the Assistant XO-BP's office to obtain the privacy needed for patient interviewing and counseling.

The Patient Assistance Representative-BP spends ninety percent of her time on the Patient Assistance work at Beach Pavilion; the Assistant XO-BP is extremely busy with building management and spends approximately ten percent of his time on Patient Assistance functions. The Patient Assistance Representative-BP performs typing duties for the Assistant XO-BP and until recently handled most of the work order requests; work order requests are now handled by the enlisted assistant to the Assistant XO-BP.[33,34]

The Patient Assistance Representative-BP reports directly to the Assistant XO-BP/Patient Assistance Officer-BP who in turn reports directly

to the BAMC XO. The Assistant Executive Officer-BP/Patient Assistance Officer-BP attends meetings in both roles--such as the morning nursing report to the CG--or only as Assistant XO-BP--Joint Staff Conference Committee, Safety and Health Council--or only as Patient Assistance Officer-BP--Central Appointments System Committee, Health Consumer Committee. The individual from the Main Hospital does not attend the morning nursing report nor the Central Appointments System Committee or Consumer Health Committee; he does attend meetings as the Assistant-XO-MH--Joint Staff Conference Committee, Safety and Health Council.[35]

The Patient Assistance Officer-BP visits wards and clinics but his visits are mainly as Assistant XO-BP in a building manager/supervisor role. The Patient Assistance Representative-BP has had little opportunity for interaction with patients on the wards until recently; with the use of enlisted personnel for processing work order requests, she has had more time for interactions on the wards and in the clinics. She serves as the notary for Beach Pavilion patients and in the past this was the extent of her interaction with patients on the wards other than for complaint resolution.

She types the individual patient complaint reports, the weekly report to the CPS, and the consolidated monthly report for the CG which includes the input from the Main Hospital. She maintains an informal log of all assistance rendered and complaints processed. She provides back-up coverage when the Patient Assistance Officer-MH is not on duty; the Patient Assistance Officer-BP provides back-up coverage when the Patient Assistance Representative-BP is not on duty.

The Patient Assistance Representative-BP is responsible for coordination of the annual outpatient satisfaction survey for the entire medical center to include distribution of forms to clinics and preparation of completed survey

forms for key punching and forwarding to HSC. She is also responsible for coordination of the semi-annual inpatient surveys for the entire medical center to include the tabulation and compilation of the results as these surveys are not computer processed.

The incumbent has been in the position for over two and one-half years and believes she was assigned the work with little preparation by the individual who preceded the current Assistant XO-BP when that individual was given the Patient Assistance function as an additional duty; she received little guidance and developed work methods on her own as a result of trial and error. During her time in the position she has attended one workshop--on customer awareness.

She appears to be dedicated and a conscientious worker, is enthusiastic about the possibilities of an expanded role as Patient Assistance Representative, enjoys working with people, but shows signs of frustration regarding the work accomplished, grade level of the position, and recognition given for work performance. Part of her frustration stems from her interactions with PROs at other HSC facilities; these have made her aware that most of the PROs accomplish tasks similar to those she performs but are graded higher than she. Additionally, many of the PROs belong to the Society for Patient Representatives but her current job description is not adequate to allow her to meet membership requirements because it does not reflect her actual duties and responsibilities.[36]

At the termination of the study attempts had been made to upgrade the Patient Assistance Representative position because the job description was recognized as out-dated and inaccurate. A revised job description for that position is included as Appendix D; it was prepared by the writer and the

Patient Assistance Representative-BP. The job description actually used for the upgrade differed from that included in this paper.

The Patient Assistance Representative-BP maintains a good working relationship with the staff at Beach Pavilion but has found frustration in some areas. Chambers Pavilion, which houses psychiatric inpatients and in which the outpatient psychiatric services are located, is part of her area of responsibility. During the past two years she has had only two complaints from Chambers Pavilion and upon interaction with a staff psychiatrist when investigating a complaint she was asked by that individual if she was aware that the patients at Chambers were "nuts." It is understandable that most of the patient advocate work at Chambers is done by the Social Work Service.[37,38]

Two other examples of her frustration and the feeling among the Patient Assistance personnel that their uncovering of problems is not given appropriate attention or recognition are given below. In the fall months of 1978, the Patient Assistant Representative-BP had received numerous complaints from patients regarding physicians in one clinic. When she attempted to discuss the problems with the service chief responsible for the clinic, he refused to assist her in solving the problem and constantly referred her to the physicians involved with whom she had had no success in resolving the problem (apparently stemming from personality or attitude problems of the physicians involved). No assistance was received from higher authorities and the only approach the Patient Assistance Representative-BP could take was to attempt to placate the patients with apologies. Complaints continued and in early 1979 a major general Medical Corps officer complained to the CG of BAMC and a colonel Veterinary Corps officer complained to the XO of BAMC about that particular clinic and those physicians. Then action was taken from BAMC Headquarters to

attempt to solve the problem. The second example involves a clinic receptionist who has a personality inappropriate for such work. The Patient Assistance Representative-BP had had numerous complaints for over a year about the rudeness of that receptionist and had discussed the complaints and the problem with the clinic chief. The clinic chief would not or could not take action because of the work involved in removing the individual or because a hiring freeze in effect at one point meant that the individual would probably not be replaced and a rude receptionist was better than none at all. Headquarters personnel were aware of the situation and made jokes occasionally about the rude receptionist but no action was taken. The Patient Assistance Representative-BP was again left with only apologies for insulted and angry patients and no solution to a recurring problem. However, when a BAMC staff physician personally complained to BAMC Headquarters about the manner in which the receptionist treated him, motions were made to transfer the receptionist to another position where she would not interact with patients. Whether or not any transfer actually takes place (none has at this writing), these two cases were perceived by the Patient Assistance personnel as indicating their lack of influence when pinpointing problems to higher authorities and underlining their inability to do other than treat symptoms--apologize and placate patients.[39]

The Patient Assistance Officer-BP was aware of the AHA Patient's Bill of Rights and the BAMC Patient's Bill of Rights. Neither the Patient Assistance Officer-MH nor the Patient Assistance Representative-BP were aware of the AHA document and neither had copies of the BAMC document. The latter document was prepared in the spring of 1978 in anticipation of the JCAH survey. During the study the BAMC document was revised (see Appendix E)

and was to be staffed for action by the IG and Patient Assistance Officer-BP.

Neither Patient Assistance Office has a procedures manual and in each office records are kept in a different manner. For a time in one office unless a patient signed the Privacy Act statement, the complaint was not recorded or documented; in the other office, the Privacy Act statement was not always presented for the patient to sign. Subsequently the records kept in the offices are neither comparable nor adequate.[40,41,42]

There appeared to be no coordination between the two offices; the NCO and the civilian who do the bulk of the assistance work do not interact to any great extent and except for report consolidation there is no focal point for the Patient Assistance functions. There was evidence of a slight friction between the offices; this may stem from the unusual organizational structure that equates a field grade officer with a senior NCO as Assistant XOs and at the same time equates the senior NCO with a GS-4 civilian as primary Patient Assistance personnel.

Attitudes of BAMC personnel toward the Patient Assistance personnel differ. Most BAMC personnel contacted on an informal basis during the seven months of the study were aware of the offices and the individuals who performed the functions but usually identified these personnel first as the Assistant XOs and the clerk who handled the work order requests and secondly as the Patient Assistance personnel. The majority perceived the offices as complaint departments concerned mostly with outpatients. Most ward personnel indicated that the IG or Social Work Service personnel handled the inpatient problems.

Members of the Social Work Service indicated that they were not convinced that the Patient Assistance personnel served the inpatients.[43,44,45]

Although one might consider this part of the problem that exists when two groups of personnel are performing similar or overlapping functions, the Patient Assistance personnel indicated they did not interact to any great extent with Social Work Service personnel, Red Cross personnel, or ward personnel and that they had some interaction with the IG but there was little coordination among all groups that receive requests for assistance and complaints--Adjutant, Social Work Service, Red Cross, IG; this was perhaps the basis for the MBO objective that addressed increased coordination of complaints with the IG as a focal point.[46,47,48]

Both the Assistant XOs/Patient Assistance Officers and the Patient Assistance Representative-BP belong to the Headquarters staff and appear on the Table of Distribution and Allowances and the Manpower Schedule X for the Headquarters.[49] Technically, the Patient Assistance Officers as members of the Special Staff report directly to the Command Group--CG, CPS, XO; in reality, the Patient Assistance Officers report to and are rated by the XO and interact at times with the CG and CPS. Technically, Patient Assistance personnel have access to all BAMC personnel when investigating problems and complaints; in reality this is not always the case.[50]

In the 1976 Manpower Survey, a requirement of two slots for the Patient Assistance functions--one MSC officer and one enlisted specialist--were recognized, not authorized, but locally allocated;[51] both slots were filled but the officer slot was vacated in 1976 and remains unfilled. In January 1979 the recognized requirement for the enlisted specialist slot was traded for a civilian slot in the Office of Graduate Medical Education; the requirements trade was approved by HSC and although the latter slot was not authorized, it was filled with an overhire.[52]

For the 1979 Manpower Survey the proposed Schedule X for the Headquarters includes slots for one MSC officer (Assistant XO-BP), an NCO (Assistant XO-MH), another NCO (work orders for Beach Pavilion), and one civilian (Patient Assistance Representative-Clerk-BP). The individual who prepared the Schedule X suggested that his work was made difficult by the Assistant XO/Patient Assistance Officer job evolution and the existing organizational structure. He suggested that in the future when more time and thought were available, the Patient Assistance functions might more appropriately be designated as a entity separate from the Assistant XOs and handled on a separate Schedule X.[58]

The current organization of the Patient Assistance functions is depicted below in Figure 1.

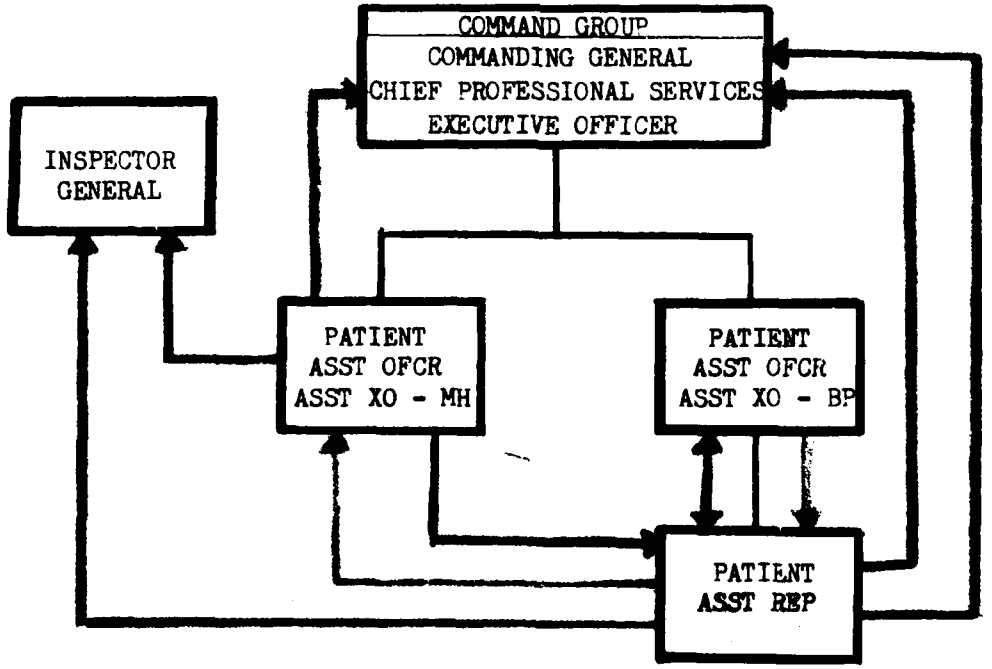

FIGURE 1

Current Organizational Structure
of Patient Assistance Functions at
Brooke Army Medical Center

The imbalances between the offices and the interactions on certain levels and lack of interaction at other levels creates the potential for problems. As can be seen, while a weekly report of complaints is sent to the CPS by each office, a monthly log is being sent to the IG (started in May 1979), and a consolidated report is sent to the CG monthly, no reports are sent to the XO although that individual is the supervisor of the Patient Assistance Officers.

Currently there is no standard form for recording individual patient complaints. A Disposition Form (DF) or Memorandum for the Record (MFR) completed by the Patient Assistance Officer-MH or the Patient Assistance Representative-BP to which is attached a Privacy Act Statement signed by the complainant are the documents used to record allegations, investigation, and results. The information contained in these records usually includes complainant identification, a statement of the complaint, and action taken to solve the problem.

The form currently used for the monthly report to the CG (see Appendix F) covers both assistance and complaints for a given month. Although the form lists areas of assistance and complaints in specific groups--waiting time, staff attitude problems, records problems, etc.--in most cases the groups are extremely broad and non-specific as to clinic, ward, service, or department; thus the information contained in the report while roughly indicating the workload of the Patient Assistance personnel does not provide enough detailed information to pinpoint trends in specific areas. The Patient Assistance personnel indicated that the majority of complaints relate to staff attitude, treatment rendered, administrative policies, waiting time for an appointment or at a clinic, and lack of adequate explanation by physicians or other health

care providers as to treatment, diagnosis, prognosis, or answers to patients' questions.[54, 55]

Additionally, all in-patient related problems are lumped together; the form is heavily weighted toward outpatient problems.

The terms "satisfactory" and "unsatisfactory" are used as a general breakdown for all assistance and complaints handled and these terms are open to interpretation; are they meant to indicate whether or not the problem was resolved to the satisfaction of the patient, BAMC personnel, or both? Several of the other categories are inappropriate as they overemphasize certain areas (such as general information and records problems) while allowing little useful information to be recorded. The Patient Assistance personnel believe the form is inadequate and does not accurately reflect workload or trends;[56] and the CG indicated to the writer that the report was of little use in its current form.

The weekly report of patient complaints to the CPS is submitted by each Patient Assistance Office on a DF and lists the area against which the complaint was made plus classification of the complaint in one of the categories listed on the monthly report to the CG. Although the former is more useful than the monthly report--it does identify specific areas--it is inadequate and also indicates the perception of the Patient Assistance Offices as complaint departments as only complaints are included in the report.

A monthly report to the IG was being initiated at the termination of the study; a log of all complaints and assistance handled during the month in each office was to be submitted in order to allow the IG to report trends to the CG. The IG stated that without such input he would not have sufficient complaint information from his files to be able to report trends to the CG.[57]

No copy of this log was available and its success cannot be indicated in this study.

Three forms are used to conduct outpatient surveys at BAMC. The Pharmacy Service uses a form specific to Pharmacy (see Appendix G) and conducts a survey annually.[58] The OB/GYN Clinic has a specific form (see Appendix H) and conducts surveys no more than semi-annually.[59] Records of the results of the surveys conducted using either form were not available and the writer was not able to ascertain the usefulness or success of such surveys.

The current outpatient satisfaction survey form is that authorized by HSC (see Appendix I) and is used annually each November and at other times as deemed appropriate by the CG. There are numerous problems with the form (in addition to those alluded to earlier in this chapter). The form is not easy to read, is crowded, contains questions that are vague (this was perhaps necessitated by the answer categories of degrees of satisfaction), contains inappropriate titles (there is no Patient Affairs Office at BAMC), and omits areas of concern (questions relating to cleanliness, explanation by care providers of treatment rendered, pharmacy service, etc.). Some of the questions are difficult to interpret. For example, when asked how satisfied one was with the "clinics", does that mean the location, the personnel, the cleanliness? When asked how satisfied one was with the "waiting room", does that mean location, number of seats, cleanliness, reading material? Examination of the form will identify additional examples.

The use and value of the demographic data required on the form is questionable; the Patient Administration Division (PAD) and the Central Appointments System (CAS) maintain the necessary demographics day by day for the facility. To classify surveyed patients by sex or eligibility for care implies

that care may also be classified and that complaints from one or another group will be given more attention or less as the case may be.

The form indicates that additional comments may be written on the reverse side of the sheet. Such free-form comments are highly valued by the Patient Assistance personnel and are viewed as important personal input from the patient as these comments are not guided by specific questions nor constrained by response category.[60,61] These comments cannot be keypunched and therefore never reach the CG when the printout of results appears.

While the computer tabulation of the survey results is statistically sound and the computer printout document is impressive in appearance, the survey results are inadequate. The presented precentages reduce patients to numbers and preclude any humanistic approach to the patients' perceptions of the care provided. A result of eighty percent "very satisfied" and "somewhat satisfied" may result from as few as eight patients out of ten or as many as thirty out of forty while a thirty percent "somewhat dissatisfied' and "very dissatisfied" may result from as few as three out of ten or as many as twelve out of forty; while statistically such percentages can be proven to be sufficient to be projected to the total population served, they are of little value in identifying specific problems. How does one use a result of less than eighty percent "very satisfied" and "somewhat satisfied" (that designated by the HSC survey instructions as requiring corrective action or investigation) in response to the question "How satisfied were you with the clinics?" in determining what caused the dissatisfaction of more than twenty percent of the patients surveyed? Although a clinic chief would be made aware that patients were dissatisfied, that individual would be hard-pressed to attempt to pinpoint what was needed as corrective action.

The inpatient survey is conducted semi-annually at BAMC and the results are compiled by the Patient Assistance Representative-BP; trends and problems gleaned from the survey are forwarded to the appropriate departments or services and the nursing supervisors. The form used is specific to BAMC (see Appendix J) and while it is not computer tabulated, it is patterned after the HSC outpatient form. Although the form has some flaws similar to the outpatient form (such as questions that are not clearly worded, specific areas that are omitted, and answers forced into the five categories of satisfaction), it is superior to the outpatient form in that it is less crowded and the questions are BAMC specific.

An ongoing method of obtaining input from patients regarding satisfaction with inpatient care is part of the discharge paperwork. Each patient has the opportunity to comment on the clearance form used by the PAD as part of the discharge procedure (see Appendix K). The patient is asked to respond "yes" or "no" to the following question: "Do you have any constructive criticisms or suggestions incident to your hospitalization?" If "yes" is the answer, the patient is asked to explain. This method of obtaining input from inpatients at discharge is a technique advocated by the AHA (although the AHA endorses a survey questionnaire[62]); the problems with the BAMC method are that the question is negative in tone and that more specific data is not solicited. The PAD forwards any form with comments to the Patient Assistance Officer-MH and that individual handles each comment as he sees fit; none are sent to the Patient Assistance Representative-BP.[63]

Alternatives to the Current System

The proposed alternative organization for the Patient Assistance

is depicted below in Figure 2.

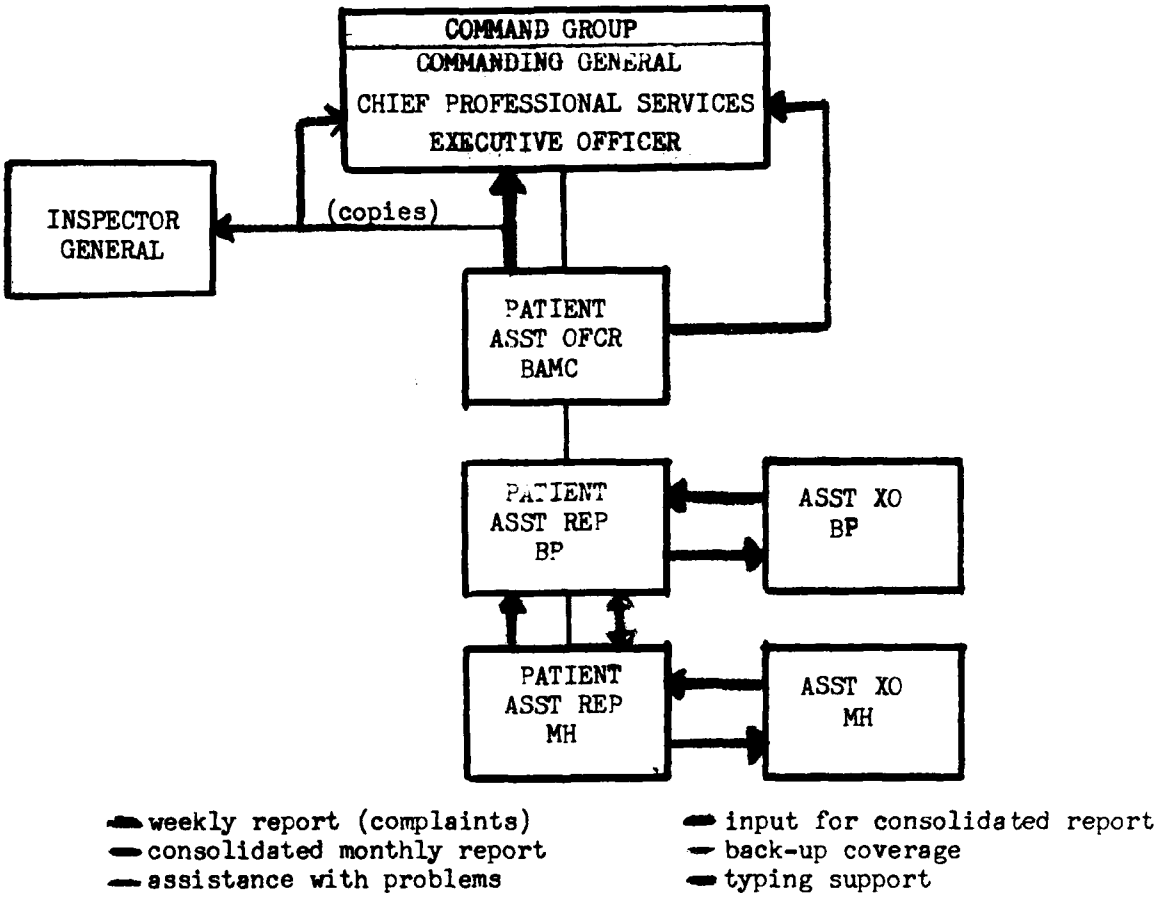

FIGURE 2

Proposed Organizational Structure
of Patient Assistance Functions at
Brooke Army Medical Center

As the planned facilities upgrade will require both Assistant XOs to become more intensely involved with building supervision (thus allowing even less time for Patient Assistance work) and will increase the need for Patient Assistance work, the Assistant XO and the Patient Assistance Officer position at each building have been split. One additional position (preferably civilian

and female--to meet needs of the OB/GYN Clinic patients) has been added for the work at the Main Hospital. The Assistant XO at each building would provide any support or assistance to the Patient Assistance Representatives for those problems within the respective facilities with which the latter individuals might have difficulty because of their or rank or status. The Patient Assistant Representatives would provide typing and office functions for the Assistant XOs. The individuals in each building would share office space and the working relationships should be mutually beneficial.

The Patient Assistance Representative-BP would be the supervisor/rater for the Patient Assistance Representative-MH and each would provide back-up support for the other; this should increase interactions between the offices and allow for more coordination and integration of effort. A BAMC Patient Assistance Officer would be the supervisor/rater for the Patient Assistance Representative-BP and have overall responsibility for the BAMC Patient Assistance Program. This officer would report to the BAMC XO and would represent the Patient Assistance Offices at required meetings.

As this position should not require a person full-time but rather a coordinator who has knowledge of the BAMC health care system and of the AMEDD and HSC modus operandi and who could perform the additional duties somewhat within the framework of his current job, the position would most appropriately be filled by the Assistant XO-BP. That individual currently attends most of the required meetings, is of field grade rank (which is appropriate for the Patient Assistance Officer for a large medical center), and occupies an office in the building where a greater percentage of the Patient Assistance needs arise.

Another officer who might be considered for the additional duty is

the IG; however, his office by its nature emphasizes complaints and there is a need to remove the current perception of the Patient Assistance Offices as complaint departments. The Public Affairs Officer is another possibility and such a choice would be in keeping with the HSC guidance; however, the current state of the Public Affairs Office precludes such an additional function being imposed upon it.

A weekly report would continue to be provided by the Patient Assistance Officer to the CPS; it would be prepared by the Patient Assistance Representative-BP using input from the Patient Assistance Representative-MH. A monthly report would be provided to the XO with copies for the CPS and the IG. As the XO is the direct supervisor of the Patient Assistance Officer, it appears more appropriate that the report of the months work be submitted to him. A copy should be provided to the CPS as between them, the CPS and the XO are responsible for all areas of the facility from which requests for assistance or complaints arise. If the CG so desired, a copy of the report could be sent directly to him; however, as he has requested a monthly report of all complaints within BAMC from the IG (to include those received and handled by Patient Assistance and the Adjutant), it is suggested that the IG attach a copy of the report as an inclosure to his monthly report to the CG. In that manner, the IG could use the Patient Assistance Offices' input for analysis of complaint trends and the CG would have access to both complaint and assistance data submitted by the Patient Assistance Offices.

The proposed form for the recording of individual patient complaints is at Appendix L. Use of the form will standardize the recording of complaints at both Patient Assistance Offices and eliminate the use of the DFs and MFRs for recording complaints. In addition to complainant identification information

the form includes designated areas for describing the complaint or request for assistance, the action taken by the Patient Assistance Representative or Officer or other BAMC personnel, other individuals involved in resolving the problem, and the time utilized per individual (can also record total time involved in resolving the problem). In addition to insuring a complete record of the complaints and subsequent actions, the form would be useful in providing statistics for workload calculations. The Privacy Act statement would be printed on the reverse side of the form (see Appendix L) to insure the complainant's permission and all the complaint data were together; it would also eliminate "forgetting" to ask the patient to sign a Privacy Act Statement.

To replace the current monthly report form, a multipurpose form is proposed. It incorporates those suggestions made by the current Patient Assistance personnel and the BAMC IG[64] and is based in part on forms used at other HSC facilities.[65,66,67] It delineates the most common complaint categories and allows for specific identification of clinics, wards, services, etc. It also contains a category titled "valid" which was included to accommodate needs expressed by the BAMC IG[68] who (for an MBO goal) was to devise criteria for classifying complaints as justified or unjustified and requested that the Patient Assistance personnel have a means of indicating the status of each complaint. As problems have occurred with the development of such criteria, the "valid" category may not be a requirement in any final configuration of the form. The proposed form and a suggested procedure for the completion of the form (with appropriate samples) are contained in Appendix M. The form would be used for the daily recording of all actions in each Patient Assistance Office and it would also be used for the weekly report to the CPS and for the monthly report to the XO.

The proposed form for use in the inpatient surveys is at Appendix N. It is based on the form suggested by the AHA, incorporates questions relating to patient rights areas outlined by the AHA and JCAH, and contains some questions and format extracted from a sample of inpatient survey forms found in the literature and received from health care facilities. Attempts have been made to insure that the proposed form includes questions relating to those areas suggested by the current Patient Assistance personnel as significant to BAMC and that it conforms to the criteria listed in Chapter I as appropriate for questionnaire design.

In using the proposed forms it is suggested that the survey of inpatients be done continuously. The value of a continous survey is that it allows each patient to provide input--not only those who chance to be in the hospital at the time the semi-annual surveys are conducted. One can note monthly or weekly trends and spot problems. With the semi-annual survey, one obtains data during two weeks of the year which is of questionable value in evaluating overall operation of the facility.

The form would be provided to each patient upon discharge (in the manner in which the current clearnace form is provided--a new clearance form minus the question relating to patient comments would be required) with a franked envelope pre-addressed to the BAMC Patient Assistance Officer. The Patient Assistance Representative-MH (whose workload would be smaller than that of the individual in the office at Beach Pavilion) would be responsible for compiling the data from the forms and providing an analysis of the information obtained (this would include the free-form comments of the patients) to the Patient Assistance Officer on a monthly or weekly basis as determined to be necessary. Information would be provided to the Patient Assistance Repre-

sentative-BP; appropriate department, service, or clinic chiefs; nursing supervisors and head nurses on wards and in clinics; and other BAMC personnel to whom the information would be of value. A monthly recap of survey results would be included as an inclosure to the monthly report to the XO. This would allow for both the pinpointing of problem areas and the provision of feedback to BAMC personnel on a continuing basis.

The proposed form for use in the outpatient surveys is at Appendix O. It is based on a sample of forms received from health care facilities and incorporates questions relating to patient rights areas outlined by the AHA and JCAH. Attempts have been made to insure that the form includes questions relating to those areas suggested by the current Patient Assistance personnel as significant to BAMC and that it conforms to the criteria listed in Chapter I.

In using the form, it is suggested that the survey be conducted on a quarterly basis; with the additional individual at the Main Hospital to assist the Patient Assistance Representative-BP, quarterly surveys would be possible. Surveys could be staggered throughout the facility; while this would not provide a "snapshot" picture as is obtained through the annual survey presently conducted, it would provide a broader view of the ambulatory patient care as perceived by the patients.

As the form would not be computer analyzed (neither the inpatient nor the outpatient forms were so devised), any free-form comments made by the patients would be included in the data compilation conducted by the Patient Assistance Offices and could be included in the analysis and information feedback provided to the clinic and service chiefs, nursing personnel, and other BAMC personnel to whom the information would be of value. A monthly recap of the surveys conducted during that month would be included as an

inclosure to the monthly report to the XO.

All proposed forms were written as starting points for staffing and modification by appropriate BAMC personnel to insure final formats that are acceptable for use at BAMC; the writer recognizes that no one person can devise a form (no matter how much input from various sources) that will be acceptable to everyone.

Footnotes

[1]U.S., Department of the Army, Public Affairs Support Model, APC Model #15 (Fort Sam Houston, Texas, 1977).

[2]Interview with Hilda Weatherford, Program Analyst, Ambulatory Patient Care Division, Deputy Chief of Staff for Professional Activities, Health Services Command, Fort Sam Houston, Texas, 26 January 1979.

[3]Interview with Gerald M. Torba, Ambulatory Patient Care Program Director, Ambulatory Patient Care Division, Deputy Chief of Staff for Professional Activities, Health Services Command, Fort Sam Houston, Texas, 26 January 1979.

[4]Interview with J. Vimont, Administrator, Ambulatory Patient Care Division, Deputy Chief of Staff for Professional Activities, Health Services Command, Fort Sam Houston, Texas, 26 January 1979.

[5]Weatherford, 26 January 1979.

[6]Torba, 26 January 1979.

[7]Weatherford, 26 January 1979.

[8]Ibid.

[9]Interview with M.C. Kullborn, Jr., Chief, Manpower Survey Branch, Force Development Division, Deputy Chief of Staff for Operations, Health Services Command, Fort Sam Houston, Texas, 24 January 1979.

[10]Telephone Interview with Jack M. Tiller, Patient Assistance Officer/ Public Affairs Officer, U.S. Army Medical Department Activity, Fort Jackson, South Carolina, 15 December 1978.

[11]Ibid.

[12]Interview with Wilford D. Wooten, Chief, Main Hospital Branch, Social Work Service, Brooke Army Medical Center, Fort Sam Houston, Texas, 27 March 1979.

[13]Interviews with: John M. Evans, Jr., Health Care Administrative Resident, U.S. Army Medical Department Activity, Fort Hood, Texas, 6 February 1979; James R. Hill, Health Care Administrative Resident, U.S. Army Medical Department Activity, Fort Belvoir, Virginia, 22 February 1979; Edward Malewski, Health Care Administrative Resident, U.S. Army Medical Department Activity, Fort Carson, Colorado, 22 February 1979; and Wilford D. Wooten, Chief, Main Hospital Branch, Social Work Service, Brooke Army Medical Center, Fort Sam Houston, Texas, 27 March 1979. Telephone Interview with Jack M. Tiller, Patient Assistance Officer/Public Affairs Officer, U.S. Army Medical Department Activity, Fort Jackson, South Carolina, 15 December 1978. Correspondence from Kenneth G. Andrews, Health Care Administrative Resident, U.S. Army Medical Department Activity, Fort Leonard Wood, Missouri, 24 October 1978; David L. Forshey, Health Care Administrative Resident, U.S. Army Medical Department Activity, Fort Knox, Kentucky, 21 March 1979; Jeanne Dickerson, Patient Affairs Representative, U.S. Army Medical Department Activity, Fort Benning, Georgia, 18 October 1978; William J. Langone, Health Care Administrative Resident, U.S. Army Medical Department Activity, Fort Polk, Louisiana, 15 November 1978; and Kent G. Washburn, Health Care Administrative Resident, U.S. Army Medical Department Activity, Fort Riley, Kansas, 20 October 1978.

[14]Interview with William Kennedy and Dennis L. Lambert, Health Care Administrative Residents, Bexar County Hospital District, San Antonio, Texas, 11 April 1979.

[15]Interview with Joseph P. O'Brien, Administrator, Cancer Therapy and Research Center, San Antonio, Texas, 16 April 1979.

[16]Interview with Michael S. Potter, Health Care Administrative Resident, Audie Murphy Memorial Veterans Administration Hospital, San Antonio, Texas, 6 April 1979.

[17]Interview with Marguerite Burt, Chief Nurse, Audie Murphy Memorial Veterans Administration Hospital, San Antonio, Texas, 5 April 1979.

[18]Interview with A.E. Zenaka, Assistant Chief Nurse, Audie Murphy Memorial Veterans Administration Hospital, San Antonio, Texas, 5 April 1979.

[19]Interview with Gary Anziani, Management Analyst, Audie Murphy Memorial Veterans Administration Hospital, San Antonio, Texas, 5 April 1979.

[20]Interview with Martin A. Hay, Health Care Administrative Resident, Wilford Hall Air Force Medical Center, Lackland Air Force Base, Texas, 23 February 1979.

[21]Interview with Richard D. Maddox, Health Care Administrative Resident, U.S. Air Force Academy Hospital, U.S. Air Force Academy, Colorado, 22 February 1979.

[22]U.S., Department of the Army, Ambulatory Patient Care, Health Services Command Regulation 40-5 (Fort Sam Houston, Texas, 1977).

[23]U.S., Department of the Army, Organization and Functions, Brooke Army Medical Center Regulation 10-1 (Fort Sam Houston, Texas, 1977).

[24]Interview with Audrey Urbanczyk, Public Affairs Officer, Brooke Army Medical Center, Fort Sam Houston, Texas, 14 December 1978.

[25]Interview with Earl C. McSwain, Jr., Executive Officer, Brooke Army Medical Center, Fort Sam Houston, Texas, 18 January 1978.

[26]Wooten, 27 March 1979.

[27]Interview with James T. Edwards, Patient Assistance Officer and Assistant Executive Officer - Main Hospital, Brooke Army Medical Center, Fort Sam Houston, Texas, 30 March 1979.

[28]Interview with Marion A. Latham, Patient Assistance Clerk, Brooke Army Medical Center, Fort Sam Houston, Texas, 26 March 1979.

[29]Edwards, 5 October 1978 and 30 March 1979.

[30]Interview with Robert E. Wright, Patient Assistance Officer and Assistant Executive Officer - Beach Pavilion, Brooke Army Medical Center, Fort Sam Houston, Texas, 15 March 1979.

[31]Latham, 15 March 1979.

[32]Edwards, 30 March 1979.

[33]Wright, 5 September 1978 and 15 March 1979.

[34]Latham, 4 October 1978; 3 January, 13, 15, 26 March 1979.

[35]U.S., Department of the Army, Hospital Boards, Committees, Conferences and Councils, Brooke Army Medical Center Regulation 15-1 (Fort Sam Houston, Texas, 1977).

[36]Latham, 13, 15, 26 March and 4 April 1979.

[37]Ibid.

[38]Interview with James D. Allen, Jr., Chief, Chambers Pavilion Branch, Social Work Service, Brooke Army Medical Center, Fort Sam Houston, Texas, 26 March 1979.

[39]Latham, 4 April 1979.

[40]Wright, 5 September 1978.

[41]Edwards, 5 October 1978.

[42]Latham, 4 October 1978.

[43]Allen, 26 March 1979.

[44]Interview with Stonell B. Greene, Chief, Brach Pavilion Branch, Social Work Service, Brooke Army Medical Center, Fort Sam Houston, Texas, 27 March 1979.

[45]Interview with Kenneth J. Nolan, Chief, Social Work Service, Brooke Army Medical Center, Fort Sam Houston, Texas, 26 March 1979.

[46]Latham, 26 March 1979.

[47]Edwards, 30 March 1979.

[48]Interview with Marshall K. Bolyard, Inspector General; Michael H. Collins, Adjutant; and Robert E. Wright, Patient Assistance Officer and Assistant Executive Officer - Beach Pavilion, Brooke Army Medical Center, Fort Sam Houston, Texas, 20 February 1979.

[49]Interview with Audrey Blair, Management Analyst and Assistant Chief, Force Development, Brooke Army Medical Center, Fort Sam Houston, Texas, 13 March 1979.

[50]Latham, 4 April 1979.

[51]Kullborn, 24 January 1979.

[52]Blair, 13 March 1979.

[53]Interview with Richard V.N. Ginn, Administrator, Office of the Chief, Professional Services, Brooke Army Medical Center, Fort Sam Houston, Texas, 16 March 1979.

[54]Latham, 3 January 1979.

[55]Edwards, 30 March 1979.

[56]Wright, 5 September 1978.

[57]Interview with Marshall K. Bolyard, Inspector General, Brooke Army Medical Center, Fort Sam Houston, Texas, 2 April 1979.

[58]Interview with Howard A. McClelland, Chief, Outpatient Pharmacy, Beach Pavilion, Brooke Army Medical Center, Fort Sam Houston, Texas, 15 March 1979.

[59]Interview with Wendy L. Farace, Head Nurse, Obstetrics/Gynecology Clinic, Brooke Army Medical Center, Fort Sam Houston, Texas, 8 January 1979.

[60]Edwards, 30 March 1979.

[61]Latham, 4 April 1979.

[62]American Hospital Association, What Do You Think About Our Hospital?, (Chicago, 1977).

[63]Edwards, 30 March 1979.

[64]Bolyard, 2 April 1979.

[65]Correspondence from Kenneth G. Andrews, Health Care Administrative Resident, U.S. Army Medical Department Activity, Fort Leonard Wood, Missouri, 24 October 1979.

[66]Correspondence from Kent G. Washburn, Health Care Administrative Resdient, U.S. Army Medical Department Activity, Fort Riley, Kansas, 20 October 1978.

[67]Correspondence from Jeanne Dickerson, Patient Affairs Representative, U.S. Army Medical Department Activity, Fort Benning, Georgia, 18 October 1978.

[68]Bolyard, 2 April 1979.

CHAPTER III

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The Patient Assistance functions at BAMC serve a vital purpose in meeting the needs of the patient population but changes are required if the consumer relations mission is to continue to be adequately fulfilled. The Patient Assistance Offices require additional staffing and must overcome their image as complaint departments. Considering other HSC facilities, BAMC appears to meet the average or slightly better in provision of Patient Assistance support. The performance of the functions could be improved for the mutual benefit of BAMC and its patient popultaion. The potential for an outstanding Patient Assistance Program exists at BAMC; it can be achieved through active command support and the incorporation of some or all of the recommendations listed below which would insure that the BAMC Program encompasses the concepts considered essential for an effective Patient Assistance Program.

Recommendations

The following actions are recommended for consideration:

--Assign a Patient Assistance Representative to the Main Hospital Patient Assistance Office (preferably a female)

--Separate the Patient Assistance functions from the Assistant XO functions and reorganize the Patient Assistance Offices to be covered by two Patient Assistance Representatives to handle the bulk of the work with a BAMC Patient Assistance Officer (preferably military) who would be responsible for the total program

--Develop a procedures manual for use in each Patient Assistance Office (to include job descriptions, sample forms, standard operating procedures, appropriate Army, HSC, and BAMC regulations--to include the APC Models)

--Compile a reference file/library in each Patient Assistance Office of informational handouts used throughout BAMC to include ward rules, information booklets handed out in clinics--those produced locally and those obtained from outside agencies, private firms, etc.--to insure that each Patient Assistance Representative has access to such items which may aid in understanding patient questions and problems (the nucleus for such a file should be available from Plans, Operations, and Training)

--Review, modify/revise, then test and evaluate the proposed forms and procedures for recording individual patient complaints, recording daily actions in the Patient Assistance Offices, submitting of weekly and monthly reports to Headquarters, and for inpatient and outpatient satisfaction surveys

--Disseminate the BAMC Patient's Bill of Rights to patients (by PAD upon admission, as handouts in clinics, etc.) and BAMC staff and insure that copies are available in the Patient Assistance Offices

--Investigate the reorganization of office spaces to insure privacy and adequate space for the Patient Assistance personnel and patients during counseling

--Publicize the Patient Assistance Offices and personnel in articles in the local service papers to insure BAMC staff and patients are aware of the Patient Assistance Program, the individuals who perform the functions, and where these individuals are located

--Insure that the Patient Assistance Program is adequately covered

in the Orientation Briefing provided to all personnel newly assigned to BAMC

--Encourage interaction between the Patient Assistance personnel and the PROs assigned to the MTFs within the BAMC Health Care Region and within HSC to stimulate sharing of ideas, work procedures, etc.

--Encourage increased interaction between the Patient Assistance personnel and BAMC ward personnel, Social Work Service, American Red Cross, PAD, and Department of Nursing

--Encourage input by the Patient Assistance personnel (based on their experiences with patients) into the BAMC Human Relations Training Program and in-service training where appropriate (such as for clinic receptionists) throughout the BAMC facility

--Insure that Patient Assistance personnel receive feedback on their work performance and encouragement as to their important contribution to the performance of the BAMC mission

--Encourage education and training opportunities for the Patient Assistance personnel

APPENDIX A

AMERICAN HOSPITAL ASSOCIATION PATIENT'S BILL OF RIGHTS

AMERICAN HOSPITAL ASSOCIATION

STATEMENT

A PATIENT'S BILL OF RIGHTS

The American Hospital Association Board of Trustees' Committee on Health Care for the Disadvantaged, which has been a consistent advocate on behalf of consumers of health care services, developed the Statement on a Patient's Bill of Rights, *which was approved by the AHA House of Delegates February 6, 1973. The statement was published in several forms, one of which was the S74 leaflet in the Association's S series. The S74 leaflet is now superseded by this reprinting of the statement.*

The American Hospital Association presents a Patient's Bill of Rights with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, his physician, and the hospital organization. Further, the Association presents these rights in the expectation that they will be supported by the hospital on behalf of its patients, as an integral part of the healing process. It is recognized that a personal relationship between the physician and the patient is essential for the provision of proper medical care. The traditional physician-patient relationship takes on a new dimension when care is rendered within an organizational structure. Legal precedent has established that the institution itself also has a responsibility to the patient. It is in recognition of these factors that these rights are affirmed.

1. The patient has the right to considerate and respectful care.

2. The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his behalf. He has the right to know, by name, the physician responsible for coordinating his care.

3. The patient has the right to receive from his physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedures and/or treatment.

4. The patient has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his action.

5. The patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in his care must have the permission of the patient to be present.

6. The patient has the right to expect that all communications and records pertaining to his care should be treated as confidential.

7. The patient has the right to expect that within its capacity a hospital must make reasonable response to the request of a patient for services. The hospital must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically permissible, a patient may be transferred to another facility only after he has received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer.

8. The patient has the right to obtain information as to any relationship of his hospital to other health care and educational institutions insofar as his care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating him.

9. The patient has the right to be advised if the hospital proposes to engage in or perform human experimentation affecting his care or treatment. The patient has the right to refuse to participate in such research projects.

10. The patient has the right to expect reasonable continuity of care. He has the right to know in advance what appointment times and physicians are available and where. The patient has the right to expect that the hospital will provide a mechanism whereby he is informed by his physician or a delegate of the physician of the patient's continuing health care requirements following discharge.

11. The patient has the right to examine and receive an explanation of his bill regardless of source of payment.

12. The patient has the right to know what hospital rules and regulations apply to his conduct as a patient.

No catalog of rights can guarantee for the patient the kind of treatment he has a right to expect. A hospital has many functions to perform, including the prevention and treatment of disease, the education of both health professionals and patients, and the conduct of clinical research. All these activities must be conducted with an overriding concern for the patient, and, above all, the recognition of his dignity as a human being. Success in achieving this recognition assures success in the defense of the rights of the patient.

APPENDIX B

JOINT COMMISSION FOR THE ACCREDITATION OF HOSPITALS
RIGHTS AND RESPONSIBILITIES OF PATIENTS

Rights and Responsibilities of Patients

The basic rights of human beings for independence of expression, decision, and action, and concern for personal dignity and human relationships are always of great importance. During sickness, however, their presence or absence become vital, deciding factors in survival and recovery. Thus it becomes a prime responsibility for hospitals to assure that these rights are preserved for their patients.

In providing care, hospitals have the right to expect behavior on the part of patients, their relatives and friends, which, considering the nature of their illness, is reasonable and responsible.

This statement does not presume to be all-inclusive. It is intended to convey the Joint Commission's concern about the relationship between hospitals and patients, and to emphasize the need for the observance of the rights and responsibilities of patients.

The following basic rights and responsibilities of patients are considered reasonably applicable to all hospitals.

Patient Rights

ACCESS TO CARE

Individuals shall be accorded impartial access to treatment or accommodations that are available or medically indicated, regardless of race, creed, sex, national origin, religion, or sources of payment for care.

RESPECT AND DIGNITY

The patient has the right to considerate, respectful care at all times and under all circumstances, with recognition of his personal dignity.

PRIVACY AND CONFIDENTIALITY

The patient has the right, within the law, to personal and informational privacy, as manifested by the right to:

- refuse to talk with or see anyone not officially connected with the hospital, including visitors, or persons officially connected with the hospital but who are not directly involved in his care.

- wear appropriate personal clothing and religious or other symbolic items, as long as they do not interfere with diagnostic procedures or treatment.
- be interviewed and examined in surroundings designed to assure reasonable audiovisual privacy. This includes the right to have a person of one's own sex present during certain parts of a physical examination, treatment, or procedure performed by a health professional of the opposite sex; and the right not to remain disrobed any longer than is required for accomplishing the medical purpose for which the patient was asked to disrobe.
- expect that any discussion or consultation involving his case will be conducted discreetly, and that individuals not directly involved in his care will not be present without his permission.
- have his medical record read only by individuals directly involved in his treatment or the monitoring of its quality, and by other individuals only on his written authorization or that of his legally authorized representative.
- expect all communications and other records pertaining to his care, including the source of payment for treatment, to be treated as confidential.
- request a transfer to another room if another patient or visitors in that room are unreasonably disturbing him by smoking or other actions.
- be placed in protective privacy when considered necessary for personal safety.

PERSONAL SAFETY The patient has the right to expect reasonable safety insofar as the hospital practices and environment are concerned.

IDENTITY The patient has the right to know the identity and professional status of individuals providing service to him, and to know which physician or other practitioner is primarily responsible for his care. This includes the patient's right to know of the existence of any professional relationship among individuals who are treating him, as well as the relationship to any other health care or educational institutions involved in his care. Participation by patients in clinical training programs or in the gathering of data for research purposes should be voluntary.

INFORMATION The patient has the right to obtain from the practitioner responsible for coordinating his care, complete and current information concerning his diagnosis (to the degree known), treatment, and any known prognosis. This information should be communicated in terms the patient can reasonably be expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to a legally authorized individual.

COMMUNICATION The patient has the right of access to people outside the hospital by means of visitors, and by verbal and written communication.

When the patient does not speak or understand the predominant language of the community, he should have access to an interpreter. This is particularly true where language barriers are a continuing problem.

CONSENT The patient has the right to reasonably informed participation in decisions involving his health care. To the degree possible, this should be based on a

clear, concise explanation of his condition and of all proposed technical procedures, including the possibilities of any risk of mortality or serious side effects, problems related to recuperation, and probability of success. The patient should not be subjected to any procedure without his voluntary, competent, and understanding consent, or that of his legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed.

The patient has the right to know who is responsible for authorizing and performing the procedures or treatment.

The patient shall be informed if the hospital proposes to engage in or perform human experimentation or other research/educational projects affecting his care or treatment, and the patient has the right to refuse to participate in any such activity.

CONSULTATION

The patient, at his own request and expense, has the right to consult with a specialist.

REFUSAL OF TREATMENT

The patient may refuse treatment to the extent permitted by law. When refusal of treatment by the patient or his legally authorized representative prevents the provision of appropriate care in accordance with ethical and professional standards, the relationship with the patient may be terminated upon reasonable notice.

TRANSFER AND CONTINUITY OF CARE

A patient may not be transferred to another facility unless he has received a complete explanation of the need for the transfer and the alternatives to such a transfer, and unless the transfer is acceptable to the other facility. The patient has the right to be informed by the responsible practitioner or his delegate of any continuing health care requirements following discharge from the hospital.

HOSPITAL CHARGES

Regardless of the source of payment for his care, the patient has the right to request and receive an itemized and detailed explanation of his total bill for services rendered in the hospital. The patient has the right to timely notice prior to termination of his eligibility for reimbursement by any third-party payer for the cost of his care.

HOSPITAL RULES AND REGULATIONS

The patient should be informed of the hospital rules and regulations applicable to his conduct as a patient. Patients are entitled to information about the hospital's mechanism for the initiation, review, and resolution of patient complaints.

Patient Responsibilities

PROVISION OF INFORMATION

A patient has the responsibility to provide, to the best of his knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his health. He has the responsibility to report unexpected changes in his condition to the responsible practitioner. A patient is responsible for making it known whether he clearly comprehends a contemplated course of action and what is expected of him.

COMPLIANCE WITH INSTRUCTIONS

A patient is responsible for following the treatment plan recommended by the practitioner primarily responsible for his care. This may include follow-

ing the instructions of nurses and allied health personnel as they carry out the coordinated plan of care and implement the responsible practitioner's orders, and as they enforce the applicable hospital rules and regulations. The patient is responsible for keeping appointments and, when he is unable to do so for any reason, for notifying the responsible practitioner or the hospital.

REFUSAL OF TREATMENT The patient is responsible for his actions if he refuses treatment or does not follow the practitioner's instructions.

HOSPITAL CHARGES The patient is responsible for assuring that the financial obligations of his health care are fulfilled as promptly as possible.

HOSPITAL RULES AND REGULATIONS The patient is responsible for following hospital rules and regulations affecting patient care and conduct.

RESPECT AND CONSIDERATION The patient is responsible for being considerate of the rights of other patients and hospital personnel, and for assisting in the control of noise, smoking, and the number of visitors. The patient is responsible for being respectful of the property of other persons and of the hospital.

APPENDIX C

PATIENT REPRESENTAIVE OFFICER
AMBULATORY PATIENT CARE MODEL #23

PATIENT REPRESENTATIVE OFFICER

AN AID FOR INNOVATION

Prepared as a requirement for the
United States Army Health Services Command
Ambulatory Patient Care (APC) Program

APC Model #23
HSPA-A
May 1977

Adopted from articles and studies written by LTC Gerald J. Sperling and LTC Frank J. Lucci.

This model supersedes APC Model #23, dated July 1974.

Section I

GENERAL

The acknowledgement of the individual's right to present grievances, when he is convinced that his needs are not being met, has long been recognized. One has only to look at any labor contract or refer to the Inspector General System of the military services to substantiate this fact. It is for this reason that larger medical facilities, both military and civilian, have established the Patient Representative Officer (PRO)/Ombudsman position. The sheer volume of recently published literature has engendered the assumption that the concept is unquestionably right, and the only thing left to be decided is the method and timing to be utilized. This model establishes the PRO as a useful and viable tool in the management of patient inquiries/complaints. It is toward this aim that the model is focused.

1. Purpose.

a. To present the concept of the PRO as one approach to managing the difficulties associated with patient inquiries and/or complaints,

b. To provide guidance to the medical treatment facility (MTF) commander for the utilization of the PRO.

c. To delineate the functions accomplished by the PRO.

d. To establish the place of the PRO in the overall organization.

2. Scope. The scope of the model is general in nature but it offers the commander sufficient information upon which a PRO position could be established. The information provided is applicable to any medical facility in which a system for handling patient inquiries/complaints does not exist. The model includes a discussion of the reasons for establishment of the PRO, the functions he performs, criteria for selection of staffing and the command channels applicable to the position.

3. Definitions.

a. Ombudsman - A representative to the managerial staff who acts on behalf of both management and the patient regarding problems experienced before, during and after the patient's visit to the hospital.

b. Patient Representative Officer (PRO) - A representative of the MTF Commander who assists patients in obtaining answers to their inquiries/complaints about medical treatment or services rendered by the MTF.

c. Inquiries - Requests, either oral or written, that are presented to the PRO by an individual in which information and/or action is required of the medical facility staff.

d. Complaints - Dissatisfaction expressed orally or in writing to a member of the MTF staff regarding the care received at a treatment facility.

Section II

DISCUSSION

4. General - The PRO, although not an entirely new concept because of the Inspectors General found in many larger facilities, has become more and more popular whether one examines an "Ombudsman" position in civilian hospitals or "Patient Representative Officer" position in military hospitals. It must be recognized that not all patients will be satisfied with the care they receive and a channel must be established to receive and process their inquiries/complaints. The MTF Commander has a useful and viable tool with which to provide this channel provided he is willing to use it. As consumers become more highly educated, this need will increase and it is important to begin now in order that the need does not outstrip the medical facility's ability to meet that need. The PRO is the most opportune system available to meet that need.

Section III

RECOMMENDATIONS

5. Appointment of a PRO - Considering the dissatisfaction witnessed daily in the delivery of health care in military medical facilities, it is important that commanders take advantage of every available tool to become aware of and manage this dissatisfaction, and where possible eliminate it. A PRO should be appointed by each MTF commander for the reasons shown. In addition, a recommended scope of activities and a list of functions to be performed is provided.

a. Reasons for Establishing a Patient Representative Officer.

(1) Education of Patients - A better educated consumer is easier to manage, because he understands the system. In discussions with patients, one quickly realizes that the less the patient knows, the simpler his whole solution seems. When the complexity of a problem is fully explained to the patient, he often becomes a firm defender of the actions taken by the medical facility.

(2) Resolution of Inquiries/Complaints. It is of crucial importance that every effort be made to insure that inquiries/complaints are handled as expeditiously as possible, if the medical facility is to achieve its desired result of patient satisfaction. This includes Congressional Inquiries.

(3) Identification of Problem Areas. Long and short range problems can often be identified if time is spent analyzing the inquiries/complaints offered by the consumer.

(4) Giving the Consumer a Voice. The PRO is an identifiable individual to whom the consumer can go to express an opinion, request information, make a suggestion or complaint and be assured of being heard.

(5) Management Emphasis. Assures the patients that their inquiries will be heard by top management and that top management is interested in their opinions.

b. Scope of Activities.

(1) Assists in the identification of potential problems.

(2) Facilitates the prompt and appropriate response to immediate and short range problems and contributes to the identification of potential problems of greater magnitude.

(3) Opens an effective two-way channel of communication between the patient and the staff.

(4) Demonstrates to the military community that there is a viable and dedicated program organized to respond to its needs and to the needs of each individual.

c. Functions to be Performed. A broad-minded approach is needed when establishing this position. The PRO is seen as one, who in identifying specific problems, is able to draw correlations, see relationships, trends, and causative factors relating to the total system which may lead to entirely different conclusions as to action needed. He does this through the following:

(1) Renders advice and assistance to the MTF commander on matters pertaining to patient inquiries.

(2) Maintains liaison with chiefs of professional and administrative services and all departments for the purpose of assisting patients and their families.

(3) Renders assistance and follow-up guidance to all patients who are referred to the PRO for the purpose of promoting good public relations between all segments of the MTF and the community which it serves.

(4) Informs the MTF commander of any situations involving patients which are now or have a potential of being serious.

(5) Assists patients with their inquiries by taking or directing them to a staff member who can assist them. If requested, he may receive inquiries/complaints and forward them to the proper staff member for action. He cuts through "red tape" and then may report the case to the Chief of Professional Services or commanding officer for their information and future use.

(6) Counsels patients regarding such matters as clarification of terminology used, schedules followed within the MTF, hospital policies and other areas as may be appropriate. It should be noted, it is not his position to interpret various military regulations, but to seek a proper authority for a correct interpretation.

(7) Seeks to correct misunderstandings patients may have concerning operation of the MTF.

(8) Follows up on cases, rendering assistance until the patient's problem is either resolved or the patient is informed of his right to continue with his inquiry/complaint through normal IG channels.

(9) Seeks to correct any breakdown in communications by determining causes and works with responsible parties to resolve any difficulties.

(10) Serves as an advocate of all consumers, not just those making inquiries/complaints.

6. Criteria for Selection of Staffing.

a. The programs currently in operation perform basically the same general functions, but choices of personnel to administer the program are varied depending on local needs and resources. Types of personnel employed include both military and civilian, with varied backgrounds, including registered nurses, paramedical personnel, public affairs personnel, or hospital administrators.

b. For consideration in determining the most suitable type personnel for a facility, rationale for selection of personnel expressed by some hospitals employing PRO is discussed below.

(1) The use of military officers is advocated by some for the following reasons:

(a) Our principal consumer is the military member.

(b) It is in keeping with the Modern Voluntary Army concept to enhance the image of the professional soldier and the health care professional as the professional soldier.

(c) It is the uniformed member who is primarily engaged in the delivery of health care.

(d) The grade 01 through 03 is most often used in order to better relate to those seeking care.

(2) The use of civilian personnel is considered more desirable by some for stability and continuity of operations. Also, the patient is less inhibited in vocalizing his complaint when there is no display of rank as in the case of a military PRO.

(3) The use of registered nurses is preferred by some, as a large number of assistance requests are for medical problems/information. It is felt that nurses' training and experience qualifies them to discuss general medical problems without the direct assistance of a physician.

(4) The use of paramedical personnel presents some of the same advantages as use of a nurse, but to a lesser degree.

(5) Others consider the use of lay personnel an advantage in providing a broader field of available personnel as compared to the critical shortages existing in nursing and paramedical personnel. Lay personnel might also offer the advantage of being more objective and less biased in favor of the medical staff.

(6) The number or mix employed to accomplish the PRO function will depend on the consumer need, physical space, personnel resources and command emphasis. Listed below are suggested standards for determining total staffing needs exclusive of clerical support. Final determination for staffing requirements should be based on average workload after six months of operation.

Average Daily Clinic Visits (Inpatient and Outpatient)	Suggested Staffing
0 - 749	0 - An additional duty
750 - 1499	1
1499 - above	2

c. Regardless of the status or background of the individual selected, the following basic characteristics are necessary.

(1) Must be acutely aware of the principles of human relations.

(2) Must be compassionate, concerned and able to recognize the dignity of the human being.

(3) Must know when to be firm in his relationships with the staff, as well as the patient.

(4) Must understand the complexity of the hospital, its organization, its staff relationships and the uniqueness and peculiarities of these relationships.

7. Command Channels. The PRO is most effective when he has direct access to the MTF commander regardless of his place of assignment. Authority should be granted to this individual to allow sufficient flexibility in contacting the appropriate staff member or department head, to resolve all but the more serious problems. Difficult situations are to be brought to the Chief of Professional Services or directly to the commander for resolution.

Section IV

SUMMARY

The Patient Representative Officer concept is relatively new, but it is felt that it is right and necessary. This model has provided a recommended scope of activities, functions to be performed, and selection criteria for staffing. The PRO is not presented as a panacea but as a useful management tool for the commander to deal with the difficult area of patient/staff relations.

The proponent agency of this model is the Deputy Chief of Staff, Professional Activities. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications) to CDR, HSC, ATTN: HSPA-A, Fort Sam Houston, TX 78234.

FOR THE COMMANDER:

PHILIP A. DEFFER, M.D.
Brigadier General, MC
Chief of Staff

THEODORA H. NAGEL
Colonel, AGC
Adjutant General

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APPENDIX D

PROPOSED JOB DESCRIPTION - PATIENT ASSISTANCE REPRESENTATIVE

JOB DESCRIPTION

PATIENT ASSISTANCE REPRESENTATIVE

SUPERVISORY CONTROLS

The Assistant Executive Officer, Beach Pavilion provides supervision in the form of general instructions and discussions concerning overall plans, objectives, and new or revised policies and procedures. Incumbent independently performs duties in connection with Patient Assistance functions referring to supervisor only those problems or situations of unprecedented policy decision or for support in controversial cases. Work performance is evaluated in terms of accomplishment of objectives through review of the overall results obtained, reports presented, and relative lack of complaints concerning services rendered.

MAJOR DUTIES

The primary purpose is to provide a source of liaison between the various elements of the hospital and patients and/or their families.

1. Renders advice and assistance on patient affairs. Acting in the capacity of representative of the Medical Center Commander, receives and processes complaints and requests for assistance on matters such as procedures, appointments, clarification of terminology, treatment, schedules, hospital policies, etc. Area of responsibility includes Beach Pavilion (378 beds and 27 clinics), Chambers Pavilion (37 beds and 4 clinics), Rhoades Dental Clinic, Garrision Dental Clinic, Annex A Troop Clinic, and the Area Medical Laboratory; incumbent also serves as back-up support for the Patient Assistance Representative at the Main Hospital. Receives verbal, written, and office caller complaints from inpatients and outpatients and/or their families. Obtains the maximum amount of utilizable information from complainant while overcoming any hostility by maintaining a sympathetic attitude and taking into consideration the frustrations and personality of the individual; determines the best approach to use in assisting the complainant and also attempts to determine from all data gathered that which is false or exaggerated. Makes inquiry into allegations to obtain a complete picture of the incident by gathering additional data from all appropriate and knowledgeable sources; during investigation procedures acts as the interface between the patient and the hospital while maintaining an objective viewpoint. Maintains liaison with chiefs of departments, divisions, services (both professional and administrative) and of other activities relaying to and obtaining from them and/or theri representatives information concerning specific cases. Resolves problems immediately, if possible (e.g. clarifies any misconceptions, misunderstandings, or lack of communication on the part of either the patient and/or family and BAMC personnel); uses diplomacy and skill in handling distraught patients and resolves problems and situations by making apologies, giving adequate and clear explanations, and taking appropriate actions where necessary (e.g. making new appointments, etc.). In those cases which cannot be resolved immediately (where additional information is needed or verification of allegations is required) informs complainant that she/he will be notified when all facts have been obtained. Follows up on such cases

rendering assistance to the individual until the questions/problems are resolved. Incumbent determines which cases are of a very serious nature and advises immediate supervisor (and IG, Chief, Professional Services, Executive Officer, Commander, as appropriate) of any repercussions and any reflection upon the medical center and/or personnel. Independent judgment, common sense, and tact are involved in maintaining close and continuous coordination with professional, technical, and clerical personnel of the clinics and wards in order to stay abreast of changes as they occur and affect the delivery of care. Also functions as Notary for those inpatients and outpatients requiring such service.

2. Maintains a continuous log of all assistance given; prepares MFRs on all complaint cases giving a brief summary of the case and the final disposition. Complies a monthly report for the Commander of assistance rendered/complaints handled for the entire medical center obtaining input from the Patient Assistance Representative at the Main Hospital. Submits a weekly report of complaints handled in Beach Pavilion to the Chief, Professional Services.

3. Conducts surveys of ongoing outpatient and inpatient medical care areas. Annual outpatient survey is an HSC requirement (although additional surveys are conducted at the discretion of the Commander) and incumbent is responsible for the processing of the surveys for the entire medical center to include distribution of survey forms to clinics and preparing the completed survey forms for key punching and forwarding to HSC. The inpatient surveys are done at least annually at the discretion of the Commander; incumbent is responsible for the processing of the surveys for the entire medical center and completed forms are complied and tabulated by hand by the incumbent for forwarding to the Commander.

4. Performs clerical tasks for the Assistant Executive Officer at Beach Pavilion to include receiving and referring visitors and telephone calls; composing correspondence from brief notes, oral instructions, or on the basis of precedence; recording and transcribing dictation for a variety of material such as letters, memoranda, etc. Maintains office files. Serves as back-up support for the receipt of work orders in the Office of the Assistant Executive Officer at Beach Pavilion when individual tasked with that job is absent from the office.

Performs other related duties as assigned.

This position has been designated and authorized as a Notary.

APPENDIX E

BROOKE ARMY MEDICAL CENTER PATIENT'S BILL OF RIGHTS

PATIENT'S BILL OF RIGHTS
BROOKE ARMY MEDICAL CENTER

1. The patient has the right to considerate and respectful care.

2. The patient has the right to obtain from his/her physician complete current information concerning diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in the patient's behalf. The patient has the right to know, by name, the physician responsible for coordinating his/her care.

3. The patient has the right to receive from his/her physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedures and/or treatment.

4. The patient has the right to refuse treatment to the extent permitted by law and military regulations, and to be informed of the medical consequences of his/her action.

5. The patient has the right to every consideration of his/her privacy concerning his/her own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly.

6. The patient has the right to expect that all communications and records pertaining to his/her care should be treated as private.

7. The patient has the right to obtain information as to any relationship of the hospital to other health care and educational institutions insofar as the patient's care is concerned. The patient has the right to obtain information as to the existence of any professional relationship among individuals, by name, who are treating him/her.

8. The patient has the right to be advised if the hospital proposes to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research projects.

9. The patient has the right to expect reasonable continuity of care. The patient has the right to know in advance what appointment times and physicians are available and where. The patient has the right to expect that the hospital will provide a mechanism whereby he/she is informed by his/her physician or a delegate of the physician of the patient's continuing health care requirements following discharge.

10. The patient has the right to examine and receive an explanation of his/her bill regardless of source of payment.

11. The patient has the right to know what hospital rules and regulations apply to his/her conduct as a patient.

12. The patient has a right to be informed of the hospital's mechanism for the initiation, review, and resolution of patient complaints.

APPENDIX F

PATIENT ASSISTANCE MONTHLY REPORT

TO	FROM Patients Assistance Officer	DATE

NO	AREA OF ASSISTANCE	SATISFACTORY	UNSATISFACTORY	TOTAL ASSISTED
A	QUALITY CARE PROBLEMS			
[1] B	RECORDS PROBLEMS			
C	APPOINTMENT PROBLEMS			
D	STAFF ATTITUDE PROBLEMS			
E	WAITING TIME (TO GET APPT)			
F	WAITING TIME (TO SEE DOCTOR)			
G	CHAMPUS			
[2] H	GENERAL INFORMATION			
I	IN-PATIENT RELATED PROBLEMS			

REMARKS	ASSISTED IN PERSON
	ASSISTED BY TELEPHONE
	TOTAL NUMBER ASSISTED

NOTES

[1] RECORDS PROBLEMS		[2] GENERAL INFORMATION	
1. NEW DEPENDENT RECORDS		1. X-RAY	
2. DEPENDENT LOST RECORDS		2. LAB	
3. MILITARY LOST RECORDS		3. PREVENTIVE MEDICINE	
SIGNATURE OF PATIENTS ASSISTANCE OFFICER		4. CLINICS	
		5. MHCS	
		6. RECORDS A & D, AND TREASURER	

BAMC F/L 24 NS
1 Oct 74

APPENDIX G

PHARMACY PATIENT QUESTIONNAIRE

PHARMACY PATIENT QUESTIONNAIRE

WE ARE ASKING THAT YOU TAKE A FEW MINUTES TO ANSWER THE FOLLOWING QUESTIONS WHILE YOU WAIT FOR YOUR PRESCRIPTION. YOUR ANSWERS WILL REMAIN ANONYMOUS AND WILL HELP US TO IMPROVE OUR OUTPATIENT PHARMACY SERVICES.

PATIENT CATEGORY: _____ DEPENDENT OF RETIRED OR DECEASED

_____ ACTIVE DUTY _____ RETIRED _____ DEPENDENT OF ACTIVE DUTY

ARE YOU AWARE THAT THE MAIN HOSPITAL PHARMACY IS OPEN 7 DAYS A WEEK UNTIL 11 O'CLOCK PM? (2300 HRS) ( ) YES ( ) NO

THE FOLLOWING QUESTIONS ARE DESIGNED TO DETERMINE YOUR SATISFACTION OR DISSATISFACTION WITH THE SERVICES PROVIDED TO YOU BY THIS PHARMACY. PLEASE USE THE SCALE BELOW IN ANSWERING THE FOLLOWING QUESTIONS;

1	2	3	4	5	6	7	8	9	10
(LOW SATISFACTION)									(HIGH SATISFACTION)

1. THE DEGREE TO WHICH THE PHARMACY HOURS OF OPERATION AGREE WITH HOURS YOU REQUIRE PRESCRIPTION SERVICES. ____
2. THE PATIENT WAITING AREA FOR THIS PHARMACY. ____
3. THE COURTESY SHOWN TO YOU BY PHARMACY PERSONNEL WHEN YOU PRESENTED AND RECEIVED YOUR PRESCRIPTION. ____
4. THE AMOUNT OF PRIVACY PROVIDED TO YOU WHEN YOU WISH TO CONSULT WITH THE PHARMACIST ABOUT YOUR MEDICATIONS. ____
5. THE TIME YOU HAD TO WAIT TO HAVE YOUR PRESCRIPTION FILLED. ____
6. YOUR OVERALL OPINION ON THE QUALITY OF PHARMACY SERVICES YOU RECEIVED. ____

THANK YOU FOR TAKING THE TIME TO ANSWER THIS QUESTIONNAIRE. IF YOU HAVE ANY ADDITIONAL COMMENTS WHEREBY WE MAY IMPROVE OUR SERVICE TO YOU, WE WOULD APPRECIATE YOUR NOTING THEM BELOW, OR ON THE BACK OF THIS SHEET. ONCE AGAIN, THANK YOU.

BAMC PHARMACY SERVICE

BAMC Form 530 NS
1 Aug 78

APPENDIX H

BROOKE ARMY MEDICAL CENTER PATIENT QUESTIONNAIRE
(OBSTETRICS/GYNECOLOGY DEPARTMENT)

PATIENT QUESTIONNAIRE
Brooke Army Medical Center
Fort Sam Houston, Texas 78234

CLINIC

DATE

PATIENT'S OPINION

Note. We would like to know what you think of us. Your opinion will have a bearing on how we can best improve our services. We have already made changes; we intend to make more. Changes for the better are contingent on fair and constructive criticism received from you. For this reason, we would appreciate your filling out the following form. You need not sign it if you do not choose.

	YES	NO
1. Was there any difficulty obtaining an appointment?		
2. Was your medical record available at the time of your appointment?		
3. Were you called to see a physician within 20 minutes of your scheduled appointment time?		
4. Was the clinic clean?		
5. Did the doctor tell you about your condition?		
6. Did the doctor explain what your proposed course of treatment would be?		
7. Do you think your doctor had a personal interest in your case?		
8. Did the nurses or volunteer workers explain what they were about to do to you?		
9. Do you feel you had as much care as needed?		
10. Was the service courteous and efficient by:		
a. Doctor(s).		
b. Nurses, volunteer workers, and aides.		
c. Receptionists and secretaries.		
d. Pharmacy personnel.		
e. Laboratory personnel.		
f. X-ray personnel.		
11. In general, do you feel that you had good medical care?		
12. Other comments:		

SIGNATURE

BAMC Form 490
1 May 77

APPENDIX I

HEALTH SERVICES COMMAND OUTPATIENT QUESTIONNAIRE

OUTPATIENT QUESTIONNAIRE

CLINIC _____ (CC 30-31) HSC MTF _____ (CC 32-33) DATE _____ TIME _____

PREFER NOT TO COMPLETE THIS QUESTIONNAIRE AT THIS TIME _____ (CC 34)

INFORMATION FOR THIS QUESTIONNAIRE WILL HELP US PROVIDE THE BEST POSSIBLE MEDICAL CARE. TO INSURE THE ACCURACY OF THIS SURVEY, IT IS MOST IMPORTANT THAT YOU ANSWER EACH QUESTION WHICH APPLIES TO TODAY'S VISIT. IT WILL TAKE ONLY ABOUT FIVE MINUTES TO COMPLETE THE QUESTIONNAIRE. ALL RESPONSES WILL BE HELD IN STRICTEST CONFIDENCE.

PLACE AN "X" IN THE APPROPRIATE BOX *(SKIP QUESTIONS THAT DO NOT APPLY)*	VERY SATISFIED	SOMEWHAT SATISFIED	UNDECIDED	SOMEWHAT DISSATISFIED	VERY DISSATISFIED
HOW SATISFIED WERE YOU WITH THE COURTESY OF:					
1. THE APPOINTMENT PERSONNEL?					
2. THE MEDICAL RECORDS ROOM PERSONNEL?					
3. THE CLINIC RECEPTIONIST?					
4. THE CLINIC MEDICAL PERSONNEL? *(Screeners, Corpsman, etc.)*					
5. THE LABORATORY PERSONNEL?					
6. THE X-RAY PERSONNEL?					
7. THE PERSONNEL IN THE PATIENTS AFFAIRS OFFICE?					
HOW SATISFIED WERE YOU WITH:					
8. THE APPOINTMENT DATE AND TIME FOR TODAY?					
9. THE HOURS THE CLINIC WAS OPEN?					
10. THE DIRECTIONS ON HOW TO LOCATE CLINICS AND SERVICES?					
11. THE PLACE(S) TO PRESENT COMPLAINTS OR SUGGESTIONS?					
12. THE INSTRUCTIONS ON HOW TO GET LABORATORY TEST RESULTS?					
13. THE INSTRUCTIONS ON HOW TO GET X-RAY RESULTS?					
HOW SATISFIED WERE YOU WITH:					
14. THE PARKING FACILITIES?					
15. THE WAITING ROOM?					
16. THE CLINICS?					
17. THE PROVISIONS TO INSURE YOUR PRIVACY?					
18. THE PUBLIC TELEPHONES?					
19. THE RESTROOMS?					
HOW DID YOU FEEL ABOUT THE WAITING TIME:					
20. TO TALK WITH THE APPOINTMENT CLERK?					
21. AT THE INFORMATION DESK?					
22. AT THE MEDICAL RECORDS ROOM?					
23. TO HAVE AN X-RAY TAKEN?					
24. TO HAVE A LABORATORY TEST TAKEN?					
25. BEFORE RECEIVING TREATMENT?					

AGE ☐☐ (CC 26-27) **SEX:** ☐ Male ☐ Female (CC 28) **STATUS:** (CC 29) ☐ Active Duty ☐ Active Duty Dependent ☐ Retired ☐ Retired Dependent ☐ Other (Civilian employee, civilian emergency, etc.)

IF YOU HAVE ANY ADDITIONAL COMMENTS OR SUGGESTIONS, PLEASE WRITE THEM ON THE REVERSE SIDE. PLEASE DEPOSIT YOUR COMPLETED QUESTIONNAIRE IN THE BOX PROVIDED OR FOLD AND RETURN TO THE PERSON WHO GAVE IT TO YOU. THANK YOU FOR TAKING TIME TO ANSWER THIS QUESTIONNAIRE.

HSC Form 128 R (DCSPA)
1 Jul 78

APPENDIX J

BROOKE ARMY MEDICAL CENTER INPATIENT QUESTIONNAIRE

INPATIENT QUESTIONNAIRE

IT IS OUR GOAL TO PROVIDE THE BEST MEDICAL CARE POSSIBLE. TO HELP US ACCOMPLISH THIS, WE ASK THAT YOU TAKE A FEW MINUTES AND COMPLETE THE FOLLOWING QUESTIONNAIRE. ALL RESPONSES WILL BE HELD IN STRICTEST CONFIDENCE.

PLACE AN "X" IN THE APPROPRIATE BOX	VERY SATISFIED	SOMEWHAT SATISFIED	UNDECIDED	SOMEWHAT DISSATISFIED	VERY DISSATISFIED
HOW SATISFIED WERE YOU WITH THE COURTESY OF:					
1. PERSONNEL ADMITTING YOU TO THE HOSPITAL?					
2. WARD CLERK?					
3. NURSING SERVICE PERSONNEL?					
4. PHYSICIAN ATTENDING YOUR CASE?					
5. HOUSEKEEPING PERSONNEL?					
6. FOOD SERVICE PERSONNEL?					
7. PERSONNEL DISCHARGING YOU FROM THE HOSPITAL?					
HOW SATISFIED WERE YOU WITH:					
1. OUR CONCERN FOR YOUR PERSONAL NEEDS?					
2. CONSIDERATION AND RESPECT SHOWN BY STAFF?					
3. PERSONAL CONCERN SHOWN BY HOSPITAL STAFF?					
4. RESPECT FOR YOUR PRIVACY AND PERSONAL DIGNITY BY STAFF?					
5. HOSPITAL RULES AND REGULATIONS YOU WERE EXPECTED TO COMPLY WITH?					
HOW SATISFIED WERE YOU WITH:					
1. ADMITTING PROCEDURES?					
2. TIME INVOLVED WITH BEING ADMITTED?					
HOW SATISFIED WERE YOU WITH:					
1. YOUR ROOM OR WARD AREA?					
2. CLEANLINESS OF HOSPITAL?					
3. BATHROOM FACILITIES?					
4. TEMPERATURE IN YOUR ROOM OR AREA?					
5. ENFORCEMENT OF WARD POLICIES?					
6. NOISE LEVELS ON WARDS?					
HOW SATISFIED WERE YOU WITH:					
1. YOUR FOOD?					
2. ANSWERS TO YOUR QUESTIONS ABOUT FOOD OR SPECIAL DIET?					
3. TEMPERATURE OF FOOD - TOO HOT OR TOO COLD (CIRCLE)					
HOW SATISFIED WERE YOU WITH:					
1. MEDICAL CARE AND TREATMENT RECEIVED?					
2. EXPLANATIONS ABOUT YOUR DIAGNOSIS, TREATMENT, PROGNOSIS?					
3. ANSWERS TO YOUR SPECIFIC QUESTIONS ABOUT MEDICAL PROBLEMS?					
4. EXPLANATIONS AS TO TYPES OF TESTS, PROCEDURES, AND TREATMENT THAT YOU RECEIVED?					
5. NURSING CARE RECEIVED ON WARD?					

BAMC Form 493
1 Jun 77

PLACE AN "X" IN THE APPROPRIATE BOX HOW SATISFIED WERE YOU WITH:	VERY SATISFIED	SOMEWHAT SATISFIED	UNDECIDED	SOMEWHAT DISSATISFIED	VERY DISSATISFIED
1. VISITATION POLICIES?					
2. ENFORCEMENT OF VISITATION POLICIES?					
3. CONDUCT OF VISITORS OF OTHER PATIENTS ON WARD?					
HOW SATISFIED WERE YOU WITH:					
1. OUR PROCEDURES FOR DISCHARGE FROM THE HOSPITAL?					
2. BILLING PROCEDURES? (WHEN APPLICABLE)					
3. ANSWERS TO QUESTIONS ABOUT YOUR BILL?					

AGE___ SEX ___MALE ___FEMALE STATUS: ___ACTIVE DUTY ___RETIRED
___ACTIVE DUTY DEP ___RETIRED DEP
___OTHER (CIVILIAN EMPLOYEE, CIVILIAN EMERGENCY, ETC.)

WARD _____

IF YOU HAVE ANY ADDITIONAL COMMENTS OR SUGGESTIONS, PLEASE WRITE THEM BELOW. PLEASE DEPOSIT YOUR COMPLETED QUESTIONNAIRE IN THE BOX PROVIDED OR FOLD AND RETURN TO THE PERSON WHO GAVE IT TO YOU. THANK YOU FOR TAKING TIME TO ANSWER THIS QUESTIONNAIRE.

SIGNATURE:_____
(OPTIONAL)

APPENDIX K

BROOKE ARMY MEDICAL CENTER PATIENT'S CLEARANCE RECORD

PATIENT'S CLEARANCE RECORD

For use of this form, see AR 40-2; the proponent agency is Office of The Surgeon General

DATE OF DISCHARGE	TIME OF DISCHARGE

SIGNATURE OF WARD OFFICER

PATIENT'S IDENTIFICATION

ACTIVITY CLEARANCE

(The final activity with whom the patient must clear will be the disposition office)

MILITARY	INITIALS*	NON-MILITARY	INITIALS*
1. PATIENT'S TRUST FUND		1. PATIENT'S TRUST FUND	
2. MEDICAL SERVICES ACCOUNT OFFICER		2. MEDICAL SERVICES ACCOUNT OFFICER	
3. CLOTHING AND BAGGAGE		3. CLOTHING AND BAGGAGE	
4. MEDICAL HOLDING UNIT		4. POSTAL SERVICE	
a. SUPPLY Med Co		5. CHANGE OF ADDRESS	
b. PAY SECTION		6. OTHER *(Specify)*	
c. SERVICE RECORDS		7. Library	
d. INSURANCE AND ALLOTMENTS		8.	
5. POSTAL SERVICE		9.	
6. [redacted] Provost Marshal		10.	
7. OTHER *(Specify)* Red Cross		11.	
8. Library		12.	
9. Special Services		13.	

REMARKS

Do you have any constructive criticisms or suggestions incident to your hospitalization? ☐ Yes ☐ No. If yes, explain in your own words.

(Signature of Patient)

DATE	SIGNATURE OF PATIENT ADMINISTRATOR
Disp Code	

*Initials of person authorizing clearance

DA FORM 1 MAR 73 4029 BAMC OP 125 REPLACES DA FORM 8-258, 1 DEC 59, WHICH WILL BE USED. ☆U.S.GPO:1978-0-765-124/205

APPENDIX L

PROPOSED FORM FOR RECORDING INDIVIDUAL PATIENT COMPLAINTS

COMPLAINT/REQUEST FORM

Date

Complainant/Requestor | Sponsor | SSN

Unit/Home Address, If Retired | Dutv-Home Phone

1. Nature and description of complaint/request:

2. Action taken:

3. Individual/individuals involved in resolving complaint/request:

4. Time utilized per individual:

DATA REQUIRED BY THE PRIVACY ACT OF 1974
(5 U.S.C. 552a)

TITLE OF FORM	PRESCRIBING DIRECTIVE
PATIENT'S REQUEST FOR ASSISTANCE/PATIENT'S COMPLAINT	HSC REG 40-5

1. AUTHORITY 5 US code 301 - Departmental Regulations; 42 US Code - Social Security Number; 10 US Code 1071-1085 - Medical and Dental Care; 44 US Code 3101 - Records Management by Agency Heads, General Duties

2. PRINCIPAL PURPOSE(S)

To assist patients in solving problems encountered while at Brooke Army Medical Center.

3. ROUTINE USES

1. To determine patient's problem.
2. To aid in investigation of the problem.
3. To assist in reaching an appropirate solution to the problem.
4. May be used in correcting problem areas within the medical center.

4. MANDATORY OR VOLUNTARY DISCLOSURE AND EFFECT ON INDIVIDUAL NOT PROVIDING INFORMATION

Voluntary - if all information is not obtained, problem may not be solved or solution may not be directed to the appropriate individual

APPENDIX M

PROPOSED FORM FOR RECORDING PATIENT ASSISTANCE ACTIONS
(MULTIPURPOSE FORM FOR DAILY/WEEKLY/MONTHLY USE)
AND
PROCEDURE FOR COMPLETION OF MULTIPURPOSE RECORD FORM

Department/Ward/ Service/Clinic/ Activity Involved	ASSIS-TANCE	COMPLAINTS										Othe
		Valid	Staff Attitude			Trtmt Rendered		Admin	Waiting Time			
			Ofcr	Enl	Civ	Prof	Para	Policy	Appt	Clinic		

Day/Week/Month

in icy	Waiting Time Appt	Clinic	Other/Comments

PROCEDURE FOR COMPLETION OF MULTIPURPOSE RECORD FORM

DAILY USE: (Office log of all actions) See SAMPLE I

1. Date sheet and use one sheet for each day--if workload is light, may use same sheet for more than one day

2. Record all assistance and complaints (include those where complainant does not sign written statement)-walk-ins, telephone calls, letters

3. To record an action:
   --list the area concerned in the first column
   --if action is assistance, check column marked "Assistance"; comments may be made in the column marked "Other" if comments will be of help in indicating potential problems
   --if action is complaint, check appropriate complaint category or if complaint does not fit listed categories briefly state complaint in the "Other" column (i.e. parking, restrooms, etc.)
   --if complaint is by letter or telephone call, may indicate such in "Other" column

4. If "Valid" classification is used, check the column marked "Valid" when it has been determined that the complaint was valid-this action need not be accomplished immediately as investigation may require time and determination may not be possible until a later date

5. Retain sheets in office for at least one month or longer as deemed necessary

WEEKLY USE: (Report of complaints for CPS) See SAMPLE II

1. Date sheet by week

2. Retitle "Assistance" column to read "Date"

3. List each area concerned individually in first column and indicate date of complaint in retitled "Date" column

4. Check appropriate complaint category or if complaint does not fit listed categories briefly state complaint in the "Other" column--when necessary elaborate on complaint in "Other" column

5. Copies of weekly report need not be maintained in office

MONTHLY USE: (Report of all actions for report to XO) See SAMPLE III

1. Date sheet by month and year

2. List each area in which actions occurred during the month--forms could be preprinted to list all possible areas which would make each monthly report longer as some areas would be blank

MONTHLY USE: (Continued)

3. To record actions:
   --for assistance rendered in each area list totals only--if a trend appears that may indicate a potential problem area, include a short explanation in the "Other" column
   --for complaints list the number of each type of complaint per area in the appropriate category using the "Other" column when necessary
   --if the "Valid" classification is to be used, list the total number of valid complaints in the column marked "Valid"; indicate the specific complaints that were valid by circling in red the numbers representing those complaints in each column; it may be necessary to include two numbers in each column--one circled in red to represent the valid complaints and a second number to indicate those complaints determined not to be valid

4. After all complaints and assistance have been listed for each area, use the "Other" column to present any observations or comments that might be helpful to Headquarters in area of Patient Assistance

5. Retain copies of the form in office for one year or longer if deemed necessary

SAMPLE I

Department/Ward/ Service/Clinic/ Activity Involved	ASSIS-TANCE	COMPLAINTS									
		Valid	Staff Attitude			Trtmt Rendered		Admin	Waiting Time		
			Ofcr	Enl	Civ	Prof	Para	Policy	Appt	Clinic	
Ortho Clinic		✓								✓	
Food Service	✓										(
Pharmacy								✓			
Ward 43 N4S	✓										(
ENT Clinic		✓			✓						
Pods Clinic		?									P
CAS								✓			
X-Ray	✓										
Derm Clinic	✓										
. . .											
. . .											
. . .											
. . .											
. . .											

I

2 APRIL 1979

Day/~~Week/Month~~

in icy	Waiting Time Appt	Clinic	Other/Comments
		✓	
			(meal card)
✓			
			(notary)
			Parking Problem
✓			

SAMPLE II

Department/Ward/ Service/Clinic/ Activity Involved	DATE ~~ASSIS-TANCE~~	COMPLAINTS								
		Valid	Staff Attitude Ofcr	Enl	Civ	Trtmt Rendered Prof	Para	Admin Policy	Waiting Time Appt	Clinic
CLINICS:										
Ortho.	2 Apr	✓								✓
ENT	2 Apr	✓			✓					
Peds.	2 Apr	?								
Ortho.	4 Apr						✓			
...	...									
...	...									
...	...									
WARDS:										
43 N+S	2 Apr	✓	✓							
12 A	3 Apr						✓			
15 A	5 Apr							✓		
...	...									
...	...									
...	...									
OTHER:										
CAS	4 Apr							✓		
Pharmacy	5 Apr							✓		
Pharmacy	6 Apr	✓			✓					
X-Ray	6 Apr	✓								✓
...	...									
...	...									
...	...									

2-6 APRIL 1979
Day/Week/Month

Waiting Time Appt	Clinic	Other /Comments
	✓	
		Parking Problem - Beach Pavilion
		(ANC)
	✓	

ASSIS-TANCE	Valid	Staff Attitude Ofcr	Enl	Civ
1				
6	3		(1)	
2	?			
	2			(2)
2				
	2	(1)		
1				
	1			
3	1			(1)
2				

APRIL 1979

~~Day/Week~~/Month

ting Time pt Clinic	Other /Comments
(1) 1	
1	
	2 Parking Complaints
	Have had such complaints for past two months
2	Had a similar complaint on same individual in Feb '79

APPENDIX N

PROPOSED INPATIENT QUESTIONNAIRE

INPATIENT OPINION QUESTIONNAIRE

It is our goal to provide the best medical care possible. To help us accomplish this, we ask that you take a few minutes and complete this questionnaire.

All responses will be held in confidence.

WARD_____ DATE_____

Please rate the following in providing you courteous and efficient service:

	EXCELLENT	GOOD	FAIR	POOR
Admitting Office Personnel.....				
Ward Clerk				
Nursing Personnel.....				
Physician(s).....				
Laboratory personnel				
X-Ray personnel				
Food Service Personnel				
Housekeeping Personnel.....				

	YES	NO
Do you feel you were treated with consideration and respect during your hospital stay?.....		
Were your privacy and personal dignity respected?.....		

Please rate the following:

	EXCELLENT	GOOD	FAIR	POOR
The explanation you received concerning the hospital schedule and the ward rules				
The explanation of tests and procedures performed				
The explanation of your illness and the explanation of the treatment provided.....				
The explanation of instructions for home care				

Where did you receive your meals? _____On ward _____In dining hall

What type diet were you on? _____Regular _____Special

Please rate the following:

	EXCELLENT	GOOD	FAIR	POOR
Tastiness and variety of the food served.....				

Please rate the following:

	EXCELLENT	GOOD	FAIR	POOR
Tastiness and variety of the food served.....				
The temperature of the food (hot foods served hot, cold foods served cold)...				
Answers to your questions about food or special diet				
Cleanliness of the room/ward area.....				
Adequacy and cleanliness of the bathroom facilities				
The procedures for your discharge from the hospital (speed, courtesy of personnel, etc.)				
What is your overall impression of the services and medical care you received?.....				

Are you aware that a Patient Assistance Representative is available to help you with any questions, suggestions, or complaints that you may have about the service and care you received?.....	YES	NO

What is your status? _____Active Duty Military _____Retired Military
_____Dependent Active Duty _____Dependent Retired/Deceased
_____Other (Please specify _____)

If you have any additional comments or suggestions, please write them on the reverse side.

Please return your completed questionnaire to the person who gave it to you or you may take it with you and return it, at your convenience, in the pre-addressed envelope provided.

Thank you for taking the time to complete this questionnaire.

Signature_____
(Optional)

APPENDIX O

PROPOSED OUTPATIENT QUESTIONNAIRE

OUTPATIENT OPINION QUESTIONNAIRE

It is our goal to provide the best medical care possible. To help us accomplish this, we ask that you take a few minutes and complete this questionnaire.

All responses will be held in confidence.

CLINIC_____ DATE_____

How long did it take you to get through to the Appointment Personnel by telephone? _____minutes

How soon were you able to get an appointment? _____days

	YES	NO
Was prompt and courteous service provided by the Appointment Personnel?		
Were your records available in the clinic when you arrived for your appointment?		
If you picked up your records at the Records Room, did you receive prompt and courteous service?		
Were you seen at the appointed time?		
If you were not seen at the appointed time, how long did you wait? _____minutes		
Did you understand the instructions and explanations given you by the physician, nurse, and/or technician?		
Were your privacy and personal dignity respected?		
Do you feel you were treated with consideration and respect by clinic medical personnel?		
Are you aware that the Patient Assistance Representative is available to listen to any suggestions or complaints that you may have about the service and care you receive?		

Please rate the following in providing you courteous and efficient service:

	EXCELLENT	GOOD	FAIR	POOR
Clinic receptionist				
Nursing personnel				
Technician(s)				
Physician(s)				
Laboratory personnel				
X-Ray personnel				
Pharmacy personnel				

Technician(s).....				
Physician(s).....				
Laboratory personnel.....				
X-Ray personnel.....				
Pharmacy personnel.....				
Please rate the following:				
Hours clinic is open.....				
Cleanliness of the clinic area....				
Adequacy/cleanliness of restrooms				
Adequacy of parking facilities....				
What is your overall impression of the services and medical care you received?.....				

What is your status?

_____Active Duty Military _____Retired Military
_____Dependent Active Duty _____Dependent Retired/Deceased
_____Other (Please specify _____)

If you have any additional comments or suggestions, please write them on the reverse side of this paper.

Thank you for taking the time to complete this questionnaire.

Signature_____
(Optional)

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